ERGO pojišťovna, a.s.

Vyskočilova 1481/4, Praha 4

Zápis v Obchodním rejstříku u Městského soudu v Praze,
oddíl B, vložka 2740, IČO: 61858714, DIČ: CZ61858714

Health insurance for foreigners - Welcome

(Welcome 170901)

Platnost od 01.09.2017

Health insurance for foreigners

Information for those interested in concluding an Insurance Policy (before concluding the Insurance Policy)

1. Information about the Insurer

A) Business name and legal form of the Insurer

ERGO pojišťovna, a.s., Company ID No.: 618 58 714, engaged in insurance activities and activities related to insurance and reinsurance activities pursuant to Act No. 277/2009 Coll., on Insurance, as amended.

B) Registered office of the Insurer

Vyskočilova 1481/4, 140 00 Prague 4, Czech Republic

C) Incorporated in the Commercial Register kept by the Municipal Court in Prague, Section B, Insert 2740

D) Name and registered office of the authority responsible for the supervision of the activities of the Insurer

Czech National Bank, with its registered office at Na Příkopě 28, 115 03 Prague 1

E) Contact information and filing complaints

By phone: +420 221 585 111

By fax: +420 221 585 555

By e-mail: stiznosti@ergo.cz

On the website: www.ergo.cz

By letter: to the Insurer's registered office

In person: at the Insurer's registered office, branches

Complaints may also be filed with the Czech Insurance Association or the Czech National Bank. In case of extrajudicial negotiations of consumer disputes concerning life insurance policies, the competent authority is the Financial Arbitrator at Legerova 1581/69, 110 00, Prague 1, www.finarbitr.cz. Concerning other insurance sectors, the competent authority is the Czech Trade Inspection Authority at Štěpánská 567/15, 120 00, Prague 2, www.coi.cz.

F) Language for communication between the Parties

Czech

G) Information on the solvency and financial situation of the Insurer

is available at www.ergo.cz in the section About the company and in the Collection of Documents of the Commercial Register kept by the Municipal Court in Prague.

2. **Information about the commitment**

A) Definition of health insurance for foreigners

The subject-matter of the Insurance consists in the provable costs associated with the stay of the Insured in the territory of the Czech Republic (hereinafter the "Czech Republic") or his/her travels to other countries of the Schengen Area incurred as medical expenses of the Insured as a result of his/her illness or accident, and the costs associated with repatriation.

This Insurance arranged by ERGO pojišťovna, a.s. is governed by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Civil Code"), and other generally binding legal regulations of the Czech Republic, the General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 170901 (hereinafter the "General Insurance Terms and Conditions"), the Insurance Policy and any other contractual arrangements.

The insurance may be taken out only by policyholders who are either individuals residing in the Czech Republic or legal entities with their registered office or branch to which the insurance relates in the Czech Republic.

B) Uninsurable persons

The following persons cannot conclude an Insurance Policy:

a) People with severe neurological disorders - these include in particular damage associated with severe physical limitations or limitations of daily life and work activities. These disorders include, among others, stages of multiple sclerosis, amyotrophic lateral sclerosis (ALS), Morbus Parkinson, conditions after strokes with limited physical abilities, epilepsy, new formation of tissue (tumours) of the central nervous system, polyneuropathy with limited physical abilities, severe brain or spinal cord injuries with limited physical abilities, depression, attacks of unconsciousness and dizziness;

b) People with mental disorders - these include in particular manic depression, schizophrenia, paranoid disorders, Morbus Alzheimer and other forms of dementia, psycho-organic syndrome, Down syndrome, hydrocephalus, autism;

c) People with the following conditions and limitations: deafness (bilateral), blindness (bilateral), paralysis, drug and alcohol addiction and addiction to medicaments, liver cirrhosis, cancer, malignant tumours (carcinoma), tuberculosis, kidney dialysis, HIV infection, AIDS.

C) Scope of Insurance Coverage

The Insurance may be arranged in the scope of “comprehensive health care”, which is provided to an extent similar to public health insurance, with the agreed exclusions and benefit limits. Therefore, the Insurance does not provide coverage in the same scope or amount in which coverage is provided under public health insurance, and it is not the same as insurance against illness pursuant to Section 2847 et seq. of the Civil Code, as amended. The Insurance may also be arranged in the scope of “necessary and urgent” health care. The scope of Insurance is based on the selected insurance policy.

D) Exclusions

Within the Insurance, no benefit is provided for the following: treatment of illnesses, injuries (accidents) and other groups of diagnoses that existed prior to the commencement of the Insurance; health care which is not paid for Czech citizens who participate in public health insurance pursuant to generally binding legal regulations; health care which is provided to the Insured Person in a medical facility which does not provide such care as standard to Czech citizens who participate in public health insurance pursuant to generally binding legal regulations, with the exception of an acute danger to life (for example, some private clinics); the costs of medication the Insured purchased without a prescription; the costs of cosmetic treatment and its after-effects, chiropractic procedures and therapy; the making and modification of prostheses, braces, glasses, contact lenses, hearing aids and similar aids; abortion, unless the life or health of the woman is in danger or unless the fetus is genetically defective, i.e. unless the abortion is medically justifiable; treatment of infertility or sterility and artificial insemination; a medical procedure and its consequences if the Insured travels to the Czech Republic or abroad in order to undergo the medical procedure; the costs of treatment carried out by a relative of the Insured (for example by his/her wife, husband, parents, etc.); spa and sanatorium treatment and rehabilitation; the costs of treatment incurred as a consequence of the application of a treatment which is not considered *lege artis* by the professional medical community; treatment of illnesses, injuries and their consequences which are caused by acts of war or participation in mass protests, events of civil unrest or other similar events; treatment of injuries caused by driving motor vehicles without the appropriate licence (driver’s licence) if such accidents occur outside the Czech Republic; transport or transfer using air ambulance, unless such transport is approved by the Assistance Service in advance; regulatory fees and additional charges; treatment in connection with the commitment of a crime or offence outside the Czech Republic; treatment as a consequence of suicide or attempted suicide outside the Czech Republic; deliberately caused illnesses and injuries outside the Czech Republic; accidents that occurred under the influence of alcohol, drugs or other psychotropic substances outside the Czech Republic.

No benefit is provided in the event the Insured refuses to undergo repatriation, treatment or necessary medical examination by a physician designated by the Insurer or the provider of the Insurer’s Assistance Services.

No benefit is provided in the event of accidents that occur during parachuting and paragliding, jumping with a parachute from heights, the use of non-motorised aircraft, powered hang gliders, ultralight aircraft and space shuttles, bungee-jumping, flying in balloons and hovercrafts; furthermore, the Insurance does not cover accidents that occur in the performance of duties of pilots, other crew members and persons engaged in business activities using aircraft; the Insurance does not cover scuba diving, including decompression, mountain climbing, rock climbing, ice and waterfall climbing, rafting, canoeing, white water rafting, alpine skiing, skiing off marked trails, motocross and motor races, karate, taekwondo, aikido, kung fu, judo, boxing, kick-boxing, etc.

The Insurance does not cover the sports activities of professional athletes.

In the Welcome Komplex policy, a Waiting Period of three months from the commencement of the Insurance applies to health care related to pregnancy, and a Waiting Period of eight months from the commencement of the Insurance applies to childbirth and the follow-up health care, i.e. the Insured Events do not include the pregnancy of the Insured Person which beyond dispute commenced before the lapse of the third month of the Term of Insurance or the related care, or a childbirth which occurred before the lapse of the eighth month of the Term of Insurance or the post-natal care relating to that childbirth.

E) Term of the Insurance Policy, Insurance Period

The insurance policy comes into effect on the day and time specified in the insurance contract as the insurance commencement. In case of insurance contracts concluded distantly, this applies only when the first premium is paid prior to the commencement of the insurance policy; therefore, the payment of the first premium shall be viewed as the acceptance of the insurance contract (offer) by the policyholder in the proposed extent. Otherwise, such insurance contract shall not be concluded.The Insurance Policy is also considered to be the Policy. The Insurance is concluded for a fixed period and ends at the time and on the date specified in the Insurance Policy as the end of Insurance. The Insurance Period is consistent with the Term of Insurance for which the Insurance is arranged. The Insurance cannot be concluded retroactively.

The minimum duration of the Insurance in the Welcome Standard and Welcome Plus policies is 1 month, in the Welcome Komplex policy 4 months and in the Welcome Baby and Welcome Dítě+ (Child+) policies 12 months.

F) Ways of terminating Insurance, withdrawal from the Insurance Policy

The Insurance terminates by agreement between the Policyholder and the Insurer; upon the expiry of the Term of Insurance; upon the expiry of the insurable interest; upon the expiry of the peril; as of the date of the death of the Insured Person or as of the date of dissolution of the legal entity without a legal successor and/or as of the date of death or dissolution of the Policyholder pursuant to Article 7(4) of the General Insurance Terms and Conditions; upon the lapse of three months from the date of conclusion of the Insurance Policy if the consent of the Insured Person has not been proven, in case such consent is required under the generally binding legal regulations; as of the date of refusal of the benefit by the Insurer pursuant to Article 5(5) of the General Insurance Terms and Conditions.

The Insurance may also terminate by notice given by the Insurer or the Policyholder. The Policyholder or the Insurer may terminate the Insurance with an eight-day notice period within two months of the conclusion of the Insurance Policy or with a one-month notice period within three months of the date of notification of an Insured Event. The Policyholder may terminate the Insurance with an eight-day notice period if the Insurer violates the principle of equal treatment when determining the amount of the Premium or when calculating the amount of the benefit; within one month of the day on which the Policyholder received a notification of the transfer of the insurance portfolio or a part thereof or a notification of a transformation of the Insurer; or within one month of the day on which it was published that the Insurer was no longer authorised to perform insurance activities. The Insurance may be terminated by the Insurer with an eight-day notice period if the Insurance Risk increases to the extent and under the conditions set out in Article 5(8)a) and Article 5(8)b) of the General Insurance Terms and Conditions. The Insurance also terminates by withdrawal from the Insurance Policy with effect as of the date of conclusion of the Insurance Policy. The Policyholder may withdraw from the Insurance Policy:

a) without giving a reason within fourteen days of the conclusion of the Insurance Policy or of the date on which the Insurance Terms and Conditions were communicated to the Policyholder if the Insurance Policy was concluded remotely or outside the premises of the Insurer;

b) if the Insurer or its authorised representative wilfully or negligently answers any written questions of the Policyholder concerning the Insurance untruthfully or incompletely when negotiating or changing the Insurance Policy. The Policyholder may exercise this right within two months of the day on which the Policyholder learned such a fact;

c) if the Insurer must have been aware of discrepancies between the offered Insurance and the requirements of the interested party when entering into the Insurance Policy and failed to inform the Policyholder of such discrepancies. The Policyholder may exercise this right within two months of the day on which the Policyholder learned such a fact. The Insurer may withdraw from the Insurance Policy if the Policyholder or the Insured wilfully or negligently answers any written questions of the Insurer concerning the Insurance untruthfully or incompletely when negotiating or changing the Insurance Policy in cases in which the Insurer would not have entered into the Insurance Policy if the Policyholder or the Insured had provided truthful and complete answers. The Insurer may exercise this right within two months of the day on which the Insurer learned such a fact. The Policyholder's withdrawal must be made in writing and sent to the address of the registered office of the Insurer. Without undue delay and no later than one month from the day of receipt of the withdrawal notice from the Insurance Policy, the Insurer is obliged to refund the paid Premium to the Policyholder, minus the benefit already paid by the Insurer, and the Policyholder, the Insured or the Beneficiary is obliged, by the same deadline, to refund to the Insurer the amount of the benefit paid which exceeds the Premium paid. The right to withdraw from the Insurance Policy expires if it is not exercised by the relevant deadline for the individual reasons described above. The form of withdrawal from the Insurance Policy is available at www.ergo.cz in the Client Service section or at the registered office or the branches of the Insurer.

G) Information on the amount of Premium

The Premium is a payment for the Insurance provided by the Insurer in the scope agreed in the Insurance Policy. The Insurer determines the amount of the Premium according to the scope of the Insurance chosen by the interested party and communicates the amount to that party before entering into the Insurance Policy. The amount of the Premium depends on the chosen policy, the age of the Insured and the scope of the Insurance. In the Premium for health insurance for foreigners, cost surcharges are calculated as 45% of the Premium.

H) Methods of payment and maturity of the Premium

The Premium may only be agreed as a Single Premium. The Single Premium is payable on the day of the commencement of the Insurance. The Policyholder is obliged to pay the Premium for the entire Term of Insurance in full upon the conclusion of the Insurance Policy. If the Premium is paid through a financial institution, a bank or a postal service operator, the Premium is deemed paid on the day the full amount is transferred to the account of the Insurer maintained by a financial institution, or by the payment of the full amount in cash to the Insurer or a person authorised by the Insurer to accept the Premium.

The first Premium may be paid in cash. The Premium must be paid in the local currency, unless otherwise agreed.

Any Premium paid without a variable symbol or with a wrong variable symbol is deemed unpaid.

I) Fees

The Insurer does not charge extra fees for using a means of remote communication. The following fees are collected in addition to the Premium:

Preparation of termination of the Insurance Policy within 2 months of the conclusion of Insurance	40% of the unused Premium
Issue of a copy of the Policy / the current status of the Insurance Policy from the system	CZK 50
Issue of a copy of the draft / Insurance Policy from the external archive	CZK 100
Issue of a confirmation of the Premium payment (on request)	CZK 50
Termination of Insurance in the event of expiry of the Insurable Interest	40% of the unused Premium

J) Law governing the Insurance Policy, dispute resolution

All insurance policies concluded with ERGO pojišťovna, a.s. are governed by the law of the Czech Republic. Any disputes will be resolved by the courts of the Czech Republic. The party interested in entering into an Insurance Policy may obtain additional information regarding health insurance for foreigners on request. If the Insurance Policy is concluded remotely, the Policyholder has the right to obtain the Insurance Terms and Conditions in paper form at any time during the term of the Insurance Policy.

3. Representations of the Policyholder

1. I have been informed, clearly, accurately, in writing and in the Czech language, of the conditions of the conclusion of the Insurance Policy, as well as of the scope of the Insurance Coverage and benefits. I have been familiarised with the above written information for parties interested in entering into an Insurance Policy and, at the same time, I have been presented with the General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 170901 for a careful reading thereof. I declare that I understand all the conditions of the conclusion of the Insurance Policy, including the definitions of the relevant terms.
2. I understand that any questions relating to the Insurance Risk when negotiating the Insurance Policy are essential for the Insurer to determine the amount of the Premium and to decide whether the Insurer should enter into the Insurance Policy (undertake to provide the Insurance Coverage). I declare that I was told the amount of the Premium before entering into the Insurance Policy.
3. I am aware that a false answer to any question relating to the Insurance Risk when negotiating the Insurance Policy may have consequences as specified in the General Insurance Terms and Conditions and in the relevant provisions of the Civil Code.
4. I am aware that I am obliged to report any change relating to the Insurance Risk during the term of the Insurance, i.e. any change in the provided answers relating to the Insurance Risk in the Insurance Policy (it is immaterial whether I consider the questions to be relevant in this respect), and that a breach of this obligation may have consequences as specified in the General Insurance Terms and Conditions and in the relevant provisions of the Civil Code.
5. I have been informed that the Insurance Policy may be withdrawn from within two months of the conclusion thereof. The notice period is 8 days. In such a case, the Insurer is entitled to the reimbursement of costs associated with the establishment and administration of the Insurance in the amount of 50% of the prescribed Premium, but no more than CZK 1,000 per Insured Person.

If an Insured Event occurs, please contact our Assistance Service **CORIS Praha, a.s.**, phone: **+420 261 222 444**.

General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 170901

General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 170901

Inception date 1.9.2017

Part I. Introductory Provisions

The health insurance for foreigners arranged with ERGO pojišťovna, a.s. (hereinafter the "Insurer") is governed by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Civil Code"), the relevant provisions of Act No. 277/2009 Coll., on Insurance, as amended, these General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 170901 (hereinafter the "General Insurance Terms and Conditions"), which form an integral part of the Insurance Policy, and any other contractual arrangements, which also form an integral part of the Insurance Policy. The Insurance meets the requirements of Act No. 326/1999 Coll., on the Residence of Foreign Nationals in the Territory of the Czech Republic, as amended.

The insurance may be taken out only by policyholders who are either individuals residing in the Czech Republic or legal entities with their registered office or branch to which the insurance relates in the Czech Republic.

Article 1 Subject-matter of Insurance

1. The subject-matter of the Insurance consists in the medical expenses of the Insured incurred due to his/her illness or accident during his/her stay in the Czech Republic, unless otherwise specified.
2. The subject-matter of the Insurance also consists in the costs associated with the repatriation of the Insured.
3. The Insurance under these General Insurance Terms and Conditions is arranged as Insurance against loss.

Article 2 Insured Event

1. An Insured Event under the health insurance for foreigners means demonstrably incurred costs associated with medical expenses of the Insured during the term of the Insurance.

Article 3 Territorial Validity of Insurance

1. The Insurance covers the Insured Events which occurred in the Czech Republic and during trips from the Czech Republic to other countries of the Schengen Area. If the Insurance is arranged as the Welcome Komplex or Welcome Baby or Welcome Child+ policy, the Insurance Coverage is provided only in the scope of "necessary and urgent health care" according to the Welcome Plus policy during trips from the Czech Republic to other countries of the Schengen Area.
2. Unless the Insurance Policy stipulates otherwise, the Insurance does not cover Insured Events which occur:
   a) in the countries in which the Insured is a national;
   b) in the countries in which the Insured pays public health insurance or is entitled to free health care.
   c) during trips from the Czech Republic to other countries of the Schengen Area in connection with the performance of work or other activity carried out for consideration.

Article 4 Establishment and Term of Insurance

1. The insurance policy comes into effect on the day and time specified in the insurance contract as the insurance commencement. In case of insurance contracts concluded distantly, this applies only when the first premium is paid prior to the commencement of the insurance policy; therefore, the payment of the first premium shall be viewed as the acceptance of the insurance contract (offer) by the policyholder in the proposed extent. Otherwise, such insurance contract shall not be concluded. The Insurance commences at the time and on the date specified in the Insurance Policy as the commencement of Insurance. The Insurance Coverage is provided if the following conditions have been met:
   a) The time and date of commencement of the Insurance specified in the Insurance Policy has come, and
   b) the Premium has been paid in full.
2. The Insurance is concluded for a fixed period, the term of the Insurance is limited to the number of days specified in the Insurance Policy. The Insurance ends at the time and on the date specified in the Insurance Policy as the end of Insurance. If medical care continues after the end of the Insurance and the Insured is not fit for repatriation, the Insurer will continue providing the Insurance Coverage until the Insured is fit for transport, but no longer than 4 weeks (i.e. 28 days) from the end of the Insurance.

Article 5 Termination of Insurance

1. The Insurance may terminate by agreement of the Insurer and the Policyholder.
2. The Insurance expires upon the lapse of the term of Insurance, unless the Insurance Policy stipulates otherwise.
3. The Insurance expires upon the expiry of the Insurable Interest. The Insurer is entitled to the Premium until the time the Insurer learns of the expiry of the Insurable Interest.

4. The Insurance expires three months from the date of conclusion of the Insurance Policy if the consent of the Insured Person has not been proven, in the case consent is required under the generally binding legal regulations.
5. The Insurance expires on the day of refusal of the benefit by the Insurer if the refusal was due to a fact:
    a) which the Insurer learned only after the occurrence of an Insured Event,
    b) which the Insurer could not have learned when negotiating the Insurance or a change thereof due to a culpable breach of the obligation of the Policyholder to provide truthful information, and
    c) which, if known by the Insurer, would have prevented the Insurer from entering into the Insurance Policy or made the Insurer conclude the Insurance Policy under different conditions.
6. Both Parties may withdraw from the Insurance:
    a) within two months of the date of conclusion of the Insurance Policy. On the day the notice is served, an eight-day notice period commences; the Insurance terminates at the end of this period;
    b) within three months of the date of notification of an Insured Event. On the day the notice is served, a one-month notice period commences, the Insurance terminates at the end of this period.
7. The Policyholder may terminate the Insurance with an eight-day notice period:
    a) within two months of the day on which the Policyholder learned that the Insurer had violated the principle of equal treatment laid down in the Civil Code when determining the amount of the Premium or when calculating the amount of the benefit;
    b) within one month of the day on which the Policyholder received a notification of the transfer of the insurance portfolio or a part thereof or a notification of a transformation of the Insurer;
    c) within one month of the day on which it was published that the Insurer was no longer authorised to perform insurance activities.
8. The Insurer may terminate the Insurance:
    a) within one month of the day on which the Insurer was notified of a change in the scope of the Insurance Risk pursuant to Article 8(5) of the General Insurance Terms and Conditions if the Insurer would not have entered into the Insurance Policy if such an Insurance Risk had existed at the time of conclusion of the Insurance Policy. On the day the notice is served, an eight-day notice period commences; the Insurance terminates at the end of this period;
    b) within two months of the day on which the Insurer learned of an increase in the Insurance Risk in the event this change was not communicated to the Insurer by the Policyholder or the Insured. The Insurance terminates on the day the notice is served.
9. The Policyholder may withdraw from the Insurance Policy:
    a) without giving a reason within fourteen days of the conclusion of the Insurance Policy or of the date on which the Insurance Terms and Conditions were communicated to the Policyholder if the Insurance Policy was concluded remotely or outside the premises of the Insurer;
    b) if the Insurer or its authorised representative wilfully or negligently answers any written questions of the Policyholder concerning the Insurance untruthfully or incompletely when negotiating or changing the Insurance Policy. The Policyholder may exercise this right within two months of the day on which the Policyholder learned such a fact; c) if the Insurer must have been aware of discrepancies between the offered Insurance and the requirements of the interested party when entering into the Insurance Policy and failed to inform the Policyholder of such discrepancies. The Policyholder may exercise this right within two months of the day on which the Policyholder learned such a fact.
10. The Insurer may withdraw from the Insurance Policy if the Policyholder or the Insured wilfully or negligently answers any written questions of the Insurer concerning the Insurance untruthfully or incompletely when negotiating or changing the Insurance Policy in cases in which the Insurer would not have entered into the Insurance Policy if the Policyholder or the Insured had provided truthful and complete answers. The Insurer may exercise this right within two months of the day on which the Insurer learned such a fact.
11. The Policyholder’s withdrawal must be made in writing and sent to the address of the registered office of the Insurer. Without undue delay and no later than one month from the day of receipt of the withdrawal notice from the Insurance Policy, the Insurer is obliged to refund the paid Premium to the Policyholder, minus the benefit already paid by the Insurer, and the Policyholder, the Insured or the Beneficiary is obliged, within the same deadline, to refund to the Insurer the amount of the benefit paid which exceeds the Premium paid.
12. The right to withdraw from the Insurance Policy expires if it is not exercised within the specified period.
13. The Insurance also terminates upon the end of the peril, as of the date of the death of the Insured Person, as of the date of the dissolution of the legal entity without a legal successor, or as of the date of the death or dissolution of the Policyholder pursuant to Article 7(4) of the General Insurance Terms and Conditions.
14. If the Insurance is terminated, the Insurer is entitled to the Premium until the end of the term of the Insurance.

Article 6 Insurable Interest

1. Insurable Interest is a legitimate need for protection against the consequences of an Insured Event, and it is the essential prerequisite for the establishment and duration of the Insurance.

2. The Policyholder has an Insurable Interest in his/her life and health. It is understood that the Policyholder also has an Insurable Interest in the life and health of a third party if the interest is proven by the relationship to such a party (i.e. kinship, a conditional benefit or advantage from the continuation of the life of that person, etc.).
3. The Policyholder has an Insurable Interest in his/her property. It is understood that the Policyholder also has an Insurable Interest in the property of a third party if the Policyholder proves that a direct property loss might be incurred by the Policyholder without the existence and preservation of such property of the third party.
4. It is understood that the Insurable Interest of the Policyholder has been proven if the Insured consents to the Insurance.
5. If the Policyholder had no Insurable Interest and the Insurer knew or must have known this when entering into the Insurance Policy, the Insurance Policy is invalid.
6. If the Policyholder deliberately insured a nonexistent Insurable Interest but the Insurer did not know and could not have known this, the Insurance Policy is invalid. In such a case, the Insurer is entitled to a fee corresponding to the Premium until the Insurer learns of such invalidity.
7. If the Insurable Interest expires during the term of the Insurance, the Insurance also expires. In such a case, the Insurer is entitled to the Premium until the time the Insurer learns of the expiry of the Insurable Interest.

Article 7 **Insurance of a Third Party's Peril and Insurance for the Benefit of a Third Party**

1. If the Policyholder concludes, for his/her own benefit, an Insurance Policy covering the peril as a possible cause of the occurrence of an Insured Event of a third party, the Policyholder may exercise the right to the benefit if the Policyholder proves that he/she has familiarised the third party with the content of the Insurance Policy and that the third party, knowing it will not be entitled to the benefit, agrees to the Policyholder receiving the benefit. If the Insured is to be a child of the Policyholder who is not fully *sui juris*, no special consent is required if the Policyholder is the legal representative of the Insured and it is not property insurance.
2. If the consent of the Insured or his/her legal representative is required and the Policyholder fails to prove such consent within three months of the date of conclusion of the Insurance Policy, the Insurance expires upon the lapse of this period. If an Insured Event occurs in this period without the consent of the Insured having been granted, the Insured becomes entitled to the benefit.
3. If the Policyholder assigns the Insurance Policy to a third party without the consent of the Insured or his/her legal representative, such an assignment of the Insurance Policy will not be taken into account. This does not apply if the assignee is a person for whom the consent to the insurance of the peril of the Insured is not required.
4. As of the day of the death of the Policyholder or as of the day of the dissolution of the Policyholder without a legal successor, the Insured enters into the Insurance; however, if the Insured informs the Insurer in writing within thirty days of the death or dissolution of the Policyholder that the Insured is not interested in the continuation of the Insurance, the Insurance is deemed to have expired as of the death or dissolution of the Policyholder. The effects of delay with respect to the Insured will not arise before the lapse of fifteen days from the date on which the Insured learned of his/her entering into the Insurance.
5. If the Insurance Policy is concluded for the benefit of a third party, this party may express its consent to the Insurance Policy subsequently when exercising the right to the benefit. The third party is entitled to the benefit if the Insured or his/her legal representative granted his/her consent to the third party to receive the benefit after the Insured or his/her legal representative has been familiarised with the content of the Insurance Policy.
6. If a third party's peril is insured for the benefit of a third party, the provisions of par. 1-4 of this Article shall apply accordingly.

Article 8 **Change in the Insurance Risk**

1. If the circumstances specified in the Insurance Policy or the circumstances asked about by the Insurer when negotiating or changing the Insurance Policy change so considerably that the probability of the occurrence of an Insured Event under the specifically agreed peril increases, the Insurance Risk will increase.
2. Without the Insurer's consent, the Policyholder may not do anything that increases the peril or allow a third party to do any such thing; if the Policyholder learns that they have allowed the peril to increase without the Insurer's consent, the Policyholder will inform the Insurer thereof without undue delay. If the peril increases independently of the will of the Policyholder, the Policyholder will inform the Insurer thereof without undue delay after the Policyholder has learned of such an increase. If a third party's Insurance Risk is insured, this obligation lies with the Insured.
3. In the event the Insurer would have concluded the Insurance Policy under different conditions had the increased Insurance Risk existed when entering into the Insurance Policy, the Insurer has the right to propose a new Premium amount. If the Insurer fails to do so within one month of the day on which the change was communicated to the Insurer, this right shall expire.
4. Unless the proposal to increase the Premium pursuant to par. 3 of this Article is accepted within one month of the date of receipt of the proposal to increase the Premium, or unless the newly determined Premium is paid within one month of the date of receipt of the proposal to increase the Premium, the Insurer has the right to terminate the Insurance with an eight-day notice period. This right of the Insurer expires if the Insurer fails to terminate the Insurance within two

months of the day on which the Insurer received disagreement with the proposal to increase the Premium, or upon the lapse of the period for its receipt.

5. In the event the Insurer, due to the conditions in force at the time of concluding the Insurance Policy, would not have entered into the Insurance Policy if the Insurance Risk in an increased scope had existed when entering into the Insurance Policy, the Insurer has the right to terminate the Insurance with an eight-day notice period. If the Insurer fails to terminate the Insurance within one month of the day on which the Insurer was informed of the change in the Insurance Risk, the Insurer's right to terminate the Insurance expires.
6. If the Policyholder or the Insured breaches the obligation to inform the Insurer of the increase in the Insurance Risk, the Insurer has the right to terminate the Insurance without a notice period. If the Insurer terminates the Insurance, the Insurer is entitled to the Premium until the end of the Insurance Period in which the Insurance terminated; in such a case, the Insurer is entitled to the Single Premium in full. If the Insurer fails to terminate the Insurance within two months of the day on which the Insurer learned of the increase in the Insurance Risk, the Insurer's right to terminate the Insurance expires.
7. If the Policyholder or the Insured breaches the obligation to inform the Insurer of the increase in the Insurance Risk and an Insured Event occurs after such a change, the Insurer has the right to reduce the benefit in proportion to the ratio of the received Premium to the Premium which the Insurer should have received if the Insurer had learned of the increase in the Insurance Risk in time.
8. The provisions on the increase in the Insurance Risk do not apply if the Insurance Risk was increased in order to avert greater damage or reduce the damage, as a result of an Insured Event or as a result of an act of humanity.

Article 9 Premium

1. The Insurer is entitled to the Premium for the term of the Insurance, unless otherwise agreed.
2. The Policyholder is obliged to pay the Premium in the agreed amount.
3. The Premium is paid in cash or to the account designated by the Insurer with the indication of the variable symbol, which is the number of the Insurance Policy. Any Premium paid without a variable symbol or with a wrong variable symbol is deemed unpaid.
4. The Premium is agreed as a Single Premium.
5. The Premium is payable on the day of the commencement of the Insurance.
6. The Premium is considered paid:
    a) if paid by bank transfer, as of the moment the relevant amount of the Premium is credited to the account of the Insurer under the correct variable symbol; for the payment of the first Premium, the Premium shall be deemed paid as of the moment of debiting the relevant amount of the Premium from the account from which the Premium is paid;
    b) if paid through a post office, on the date the payment is made at the post office;
    c) if paid in cash, on the date of payment to the Representative of the Insurer against an issued confirmation of the received payment.
7. The amount of the Premium is governed by the initial age of the Insured, the chosen policy and the length of the Insurance.
8. If an Insured Event occurred due to which the Insurance terminated, the Insurer is entitled to the Premium until the end of the Insurance Period in which the Insured Event occurred; in such a case, the Insurer is entitled to the Single Premium for the entire period for which the Insurance has been arranged, unless agreed otherwise.

Article 10 Scope of Insurance

1. The Insurance is arranged in the scope of "comprehensive health care", which is provided in a scope similar to public health insurance, with the agreed exclusions and benefit limits. Therefore, the Insurance does not provide coverage in the same scope or amount in which coverage is provided under public health insurance, and it is not the same as insurance against illness pursuant to Section 2847 et seq. of the Civil Code, as amended.
2. The Insurance covers the treatment of illnesses, injuries and other groups of diagnoses that occurred after the commencement of the Insurance.
3. The Insurance covers only medical care provided by qualified medical personnel.
4. The Insurance covers:
    a) outpatient medical treatment;
    b) prescription medication; medication does not include supportive medication, even if it is prescribed and contains medical components, preventive medicines, cosmetics or drugs;
    c) medical aids related to the treatment of the Insured (plaster, bandages, crutches, etc.);
    d) physical therapy if prescribed, for example radiation and heat treatment, etc.;
    e) diagnostic tests (X-ray, EEG, ECG etc.);
    f) in the case of stationary treatment, standard placement in a hospital according to the rules of the local statutory provisions, which is under constant medical supervision, has sufficient therapeutic and diagnostic capabilities, operates according to generally accepted scientific methods and keeps relevant files;
    g) the costs of medically indicated transport to the nearest suitable hospital or doctor;

h) urgent surgery;
i) the costs of medication purchased on prescription;
j) a check-up if the first treatment of the diagnosis was paid by the Insurer; k) dental treatment due to an accident.

5. The Insurance also covers:
   a) regular outpatient care related to illnesses and injuries, the cause of which arose after the commencement of the Insurance;
   b) treatment in connection with an allergy if it is the first occurrence of the given type of allergy for the Insured Person, including the necessary follow-up allergy or immunological tests; however, the Insurance does not cover any medicaments or supporting preparations related to the diagnosis;
   c) any medical care which the Insured Person undergoes in connection with pregnancy and childbirth in the Czech Republic in a contractual facility of the Insurer or other facility approved by the Insurer in advance. Such care includes any medical examination undergone by the Insured Person during pregnancy, childbirth, continuous post-childbirth hospitalisation and the first subsequent gynaecological examination in the postpartum period after discharge from hospital;
   d) Dental treatment in order to eliminate pain, a simple dental filling and a necessary repair of dentures, all up to the limit of CZK 6,000 per Insurance Year for each Insured Person under all Insurance Policies of that Insured Person.
6. The Insurance also covers preventive care in the following scope:
   a) for children up to 5 years of age, all preventive examinations by a medical practitioner up to the limit of CZK 3,000 per Insurance Year (subject to an Insurance Policy entered into for at least 12 months);
   b) for children under 18 years of age, a preventive examination by a medical practitioner once per Insurance Year;
   c) for adults, a preventive examination by a medical practitioner once every two Insurance Years;
   d) for women over 15 years of age, a preventive examination by a gynaecologist once per Insurance Year;

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   e) a preventive examination by a dentist once per Insurance Year;
   f) mandatory vaccinations up to the limit of CZK 1,000 per Insurance Year.
7. The Insurer will provide the benefit for medical care provided within the scope of the entitlement of Czech citizens who pay public health insurance pursuant to the applicable legislation.
8. If the Insured dies due to an accident or illness, the Insurance covers the adequate and reasonable costs of:
   a) cremation at the place of death;
   b) repatriation, i.e. the costs of a temporary coffin, embalming and transport of the remains in accordance with the relevant legislation.
9. The total benefit per one Insured Event is limited to the amount of EUR 80,000. This amount constitutes the limit and may not be exceeded in the sum of the individual costs of medical care, including potential repatriation.

Article 11 Assistance Services

1. Assistance Service is a service provided to the Insured in connection with the arranged Insurance by a contractual partner of the Insurer.
2. The Assistance Service provider or other authorised foreign Representative of the Insurer has the right to act on behalf of the Insurer if any Loss or Insured Events occur, and to recommend or find a suitable medical facility.
3. Assistance Service is provided if the following is needed:
   a) transport or transfer in the event of illness or accident of the Insured;
   b) transport of the remains of the Insured;
   c) guarantee of the Insurance Coverage and the payment of the treatment costs by the Insurer.

Article 12 Waiting Period

1. The Waiting Period applies only to the Insurance arranged in the scope of “comprehensive health care”. The Waiting Period commences on the day of commencement of the Insurance.
2. A Waiting Period of 3 months applies to medical care related to pregnancy pursuant to Article 10(5)c) of the General Insurance Terms and Conditions, i.e. the pregnancy of the Insured Person or the related care is not an Insured Event if such a pregnancy unquestionably commenced before the lapse of the third month of the Term of Insurance.
3. A Waiting Period of 8 months applies to childbirth and the follow-up medical care pursuant to Article 10(5)c) of the General Insurance Terms and Conditions, i.e. childbirth or the related follow-up care is not an Insured Event if the childbirth took place before the lapse of the eighth month of the Term of Insurance.
4. The Waiting Period pursuant to par. 2 and 3 of this Article does not apply in the case of a necessary treatment in the event of pregnancy complications in which the lives of the mother and child are in danger; in such a case, the benefit will be paid according to the scope of “necessary and urgent health care”.
5. The Waiting Period does not apply in cases in which the Insured Person had health insurance for foreigners arranged with the Insurer for at least one year immediately preceding the commencement of the Insurance.

Article 13 Payment and Maturity of the Benefit

1. If an Insured Event occurs after the commencement of the Insurance Coverage, the Insurer will provide the benefit under the conditions set out in the Insurance Policy. The benefit is payable in the Czech Republic in the local currency and is provided to the Insured or the person entitled to the benefit.
1. For the conversion of foreign currency, the exchange rate officially announced by the Czech National Bank as of the date of the Insured Event will be used.
2. The upper limit of the benefit is determined by the Insured Amount and may be limited by the benefit limit.
3. The Insurer will complete the investigation and communicate its results to the Entitled Person within 3 months of the date of notification of the Loss Event to the Insurer. If the Insurer is unable to complete the investigation within this period, the Insurer will inform the person who is entitled or is supposed to be entitled to the benefit of the reasons for which the investigation cannot be completed, and at the request of that person, the Insurer will provide the person with a reasonable advance if there is no legitimate reason for its refusal. This period does not run if the investigation is prevented or hindered by the Entitled Person, the Policyholder or the Insured. The benefit is payable within 15 business days of the completion of the investigation necessary to determine the extent of the Insurer's obligation to pay the benefit. The investigation is completed once the Insurer communicates its results to the Entitled Person.
4. The Insurer is entitled to postpone the payment of the benefit or advance if:
    a) there is doubt concerning the legitimacy of the payment of the benefit, until the submission of the necessary evidence;
    b) criminal, administrative or other judicial proceedings have been initiated against the Policyholder or the Insured in connection with the Loss Event, until the end of such proceedings.
5. If the benefit or advance has been paid in error, the person to whom the benefit has been paid is obliged to refund the benefit without delay, even after the termination of the Insurance.
    a)
6. If the costs of the investigation incurred by the Insurer were caused or increased by the breach of an obligation by the Policyholder, the Insured or other person who exercises the right to the benefit, the Insurer is entitled to demand the person who breached the obligation to pay reasonable compensation.
7. If the Insured becomes entitled to a financial compensation from a third party in connection with an Insured Event and such a financial compensation is the subject-matter of this Insurance, the right to such financial compensation shall pass to the Insurer up to the amount of the benefit paid under the Insurance Policy. If the Insured waives this right or entitlement without the consent of the Insurer, the Insurer is not obliged to pay any benefit up to the amount of the claim against the third party; in the event the benefit has already been paid, the Insured is obliged to refund the benefit to the Insurer in the amount of the claim against the third party.
8. If the Insured receives a payment from a third party that is obliged to make such a payment, the Insurer is entitled to reduce the benefit adequately. The Insured is obliged to inform the Insurer of such a fact without delay.
9. If the Insured is entitled to the payment of medical care under public health insurance or similar statutory security, the Insurer is obliged to provide the benefit only beyond the framework of the payment under public health insurance or similar statutory security. The Insured is not entitled to waive his/her claims. If the Insured waives his/her claims, the Insurer is entitled to proportionally reduce the benefit by the amount corresponding to that claim.
10. Claims for the benefit may only be assigned to a third party with the prior written consent of the Insurer.

Article 14 Refusal and reduction of the benefit

1. The Insurer may refuse to pay the benefit under the Insurance Policy if the Insured Event was caused by a fact which the Insurer learned only after the occurrence of the Insured Event and which the Insurer could not have learned when negotiating or changing the Insurance due to an intentional or negligent provision of untruthful or incomplete written answers by the Policyholder or the Insured, in the event the Insurer would not have concluded the Insurance Policy or would have concluded it under different conditions if the Insurer had known the fact at the time of entering into the Insurance Policy.
2. As of the date of delivery of the notification of refusal to provide the benefit under par. 1 of this Article, the Insurance will terminate.
3. If the Policyholder or the Insured breaches any of the obligations set out in the Insurance Policy when negotiating or changing the Insurance Policy, and lower Premiums are agreed as a result of such a breach, the Insurer has the right to proportionally reduce the benefit by an amount corresponding to the share of the Premium which the Insurer received to the Premium which the Insurer should have received.
4. If the breach of obligations by the Policyholder, the Insured or other person entitled to the benefit significantly affected the occurrence or progress of the Insured Event, caused an increase in the scope of its consequences or affected the determination of the amount of the benefit, the Insurer may reduce the benefit in proportion to the influence of the breach on the extent of the Insurer's obligation to pay the benefit. This also applies in cases in which the breach of obligations made it impossible to submit evidence of the Insured Event pursuant to these General Insurance Terms and Conditions.
5. If premium medical care is provided, the Insurer is entitled to reduce the benefit to the necessary and reasonable extent according to the opinion of a medical expert designated by the Insurer.

Article 15 Exclusions

1. The Insurance does not cover:
   a) treatment of illnesses, injuries (accidents) and other groups of diagnoses that existed prior to the commencement of the Insurance;
   b) health care which is not paid for Czech citizens who participate in public health insurance pursuant to generally binding legal regulations;
   c) health care which is provided to the Insured Person in a medical facility which does not provide such care as standard to Czech citizens who participate in public health insurance pursuant to generally binding legal regulations (for example some private clinics and other health care facilities whose services are not covered by public health insurance), with the exception of an acute danger to life;
   d) the costs of medication which the Insured purchased without a prescription;
   e) the costs of cosmetic treatment and its after-effects, chiropractic procedures and therapy;
   f) the making and modification of prostheses, braces, glasses, contact lenses, hearing aids and similar aids;
   g) abortion, unless the life or health of the woman is in danger or unless the fetus is genetically defective, i.e. unless the abortion is medically justifiable;
   h) treatment of infertility or sterility and artificial insemination;
   i) a medical procedure and its consequences if the Insured travels to the Czech Republic or abroad in order to undergo the medical procedure;
   j) the costs of treatment carried out by a relative of the Insured (for example by his/her wife, husband, parents etc.);
   k) spa and sanatorium treatment and rehabilitation;
   l) the costs of treatment incurred as a consequence of the application of a treatment which is not considered *lege artis* by the professional medical community;
   m) treatment of illnesses, injuries and their consequences caused by acts of war or participation in mass protests, events of civil unrest or other similar events;
   n) treatment of injuries caused by driving motor vehicles without the appropriate licence (driver's licence) if such accidents occur outside the Czech Republic;
   o) transport or transfer using air ambulance, unless such transport is approved by the Assistance Service in advance;
   p) regulatory fees and additional charges;
   q) treatment in connection with the commitment of a crime or offence outside the Czech Republic;
   r) treatment as a consequence of suicide or attempted suicide outside the Czech Republic;
   s) deliberately caused illnesses and injuries outside the Czech Republic;
   t) accidents that occurred under the influence of alcohol, drugs or other psychotropic substances outside the Czech Republic.
2. No benefit is provided by the Insurer in the event the Insured refuses to undergo repatriation, treatment or necessary medical examination by a physician designated by the Insurer or the provider of the Insurer's Assistance Services.
3. The Insurance does not cover accidents that occur during parachuting and paragliding, jumping with a parachute from heights, the use of non-motorised aircraft, powered hang gliders, ultralight aircraft and space shuttles, bungee-jumping, flying in balloons and hovercrafts; furthermore, the Insurance does not cover accidents that occur in the performance of duties of pilots, other crew members and persons engaged in business activities using aircraft; the Insurance does not cover scuba diving including decompression, mountain climbing, rock climbing, ice and waterfall climbing, rafting, canoeing, white water rafting, alpine skiing, skiing off the marked trails, motocross and motor races, karate, taekwondo, aikido, kung fu, judo, boxing, kick-boxing, etc.
4. The Insurance does not cover the sports activities of professional athletes. According to these General Insurance Terms and Conditions, a professional athlete is a person who performs sports activities under a professional contract; a person who participates in competitions, races, tournaments or trainings at the level of the World Cup, the Olympics, or world, continental or national championships.
5. The activities under par. 3 and 4 of this Article may be included in the Insurance upon a written agreement with the Insurer or insured for higher Premiums and under the conditions according to the price list of the Insurer.

Article 16 Uninsurable persons

1. The following persons are uninsurable and therefore uninsured:
   a) people with severe neurological disorders - these include in particular damage associated with severe physical limitations or limitations of daily life and work activities. These disorders include, among others, stages of multiple sclerosis, amyotrophic lateral sclerosis (ALS), Morbus Parkinson, conditions after strokes with limited physical abilities, epilepsy, new formation of tissue (tumours) of the central nervous system, polyneuropathy with limited physical abilities, severe brain or spinal cord injuries with limited physical abilities, depression, attacks of unconsciousness and dizziness;

b) people with mental disorders - these include in particular manic depression, schizophrenia, paranoid disorders, Morbus Alzheimer and other forms of dementia, psycho-organic syndrome, Down syndrome, hydrocephalus, autism;
c) People with the following conditions and limitations: deafness (bilateral), blindness (bilateral), paralysis, drug and alcohol addiction and addiction to medicaments, liver cirrhosis, cancer, malignant tumours (carcinoma), tuberculosis, kidney dialysis, HIV infection, AIDS.

2. No Insurance will be concluded with an uninsurable person.

Article 17 Obligations of the Policyholder and the Insured

1. The Policyholder and the Insured are obliged to truthfully and completely answer any questions of the Insurer when negotiating the conclusion of the Insurance Policy or when negotiating changes to the Insurance Policy, as well as provide any facts which are relevant to the Insurer's decision on how the Insurer will assess the Insurance Risk, whether the Insurer will insure such an Insurance Risk and under what conditions the Insurer will provide such Insurance, including questions regarding the health condition of the Insured. The Policyholder and the Insured are further obliged to inform the Insurer without undue delay of any changes in the facts about which they were asked when negotiating the conclusion of the Insurance Policy or when negotiating changes to the Insurance Policy.
2. The Policyholder and the Insured are obliged, without undue delay, to inform the Insurer in writing of any change relating to the Insured, the Insurance and the Insurance Risk, in particular:
   a) a change in the place of residence, i.e. the mailing address;
   b) to notify the Insurer that the Policyholder or the Insured has entered into another insurance against the same peril with another insurer; the Policyholder and the Insured are obliged to disclose the name of that insurer and the amount of the Insured Amount;
   c) to notify the Insurer of the expiry of the Insurable Interest and prove the expiry.
3. The Policyholder and the Insured are obliged to adopt reasonable measures to avert impending damage and to try and ensure that no Insured Event occurs, especially to fulfil the obligations aimed at averting or reducing the peril set out in the generally binding legal regulations or the Insurance Policy.
4. If a Loss Event occurs, the Insured, the Policyholder and the Entitled Person are obliged to:
   a) without undue delay, inform the Insurer of the Loss Event, give a truthful explanation of the occurrence and severity of the event, submit any required original documents or allow the Insurer to make copies of such documents, and proceed in the manner as agreed in the Insurance Policy and according to the instructions of the Insurer;
   b) at the request of the Insurer, provide the Insurer with any information in writing which is necessary to determine the extent of the Insurer's obligation to pay the benefit. The requested information may also be provided to the Representative of the Insurer by written communication. Any costs associated with the preparation of the requested documents shall be borne by the Insured or other Entitled Person. Documents submitted to the Insurer become the property of the Insurer, and the Insurer is entitled to dispose of such documents;
   c) at the request of the Insurer, empower the Representative of the Insurer to request any necessary information from a third party (i.e. in particular from physicians, hospitals, all kinds of medical facilities and insurance companies) and to act in relation to the Loss Event;
   d) strive to ensure that any reports and opinions required by the Insurer are prepared and sent to the Insurer without undue delay;
   e) prove the date of the start of a trip abroad to the Insurer;
   f) immediately notify criminal justice authorities of the occurrence of any Loss Event which occurred under circumstances suggesting that a crime was committed or attempted;
   g) secure the right to damages and other similar rights, and enforce the claim to compensation against the liable person;
   h) in the case of documents in a foreign language, submit an official translation into Czech to the Insurer, prepared at the expense of the Insured, the Policyholder or the Entitled Person;
   i) submit original bills and invoices that must contain the first name and surname of the person treated, the diagnosis, information about the individual medical procedures including the costs of the treatment, and any medical reports relating to the treatment;
   j) submit prescriptions clearly stating the name of the prescribed medication, price, the first name and surname of the Insured and the stamp of the attending physician;
   k) in the case of dental treatment, submit to the Insurer the medical report indicating the individual teeth and describing the treatment.
5. In order to clarify the obligation to pay the benefit, the Insurer may require additional necessary documents and carry out necessary investigations.

Article 18 Consequences of a Breach of Obligations

1. If the Policyholder or the Insured breaches any of the obligations set out in the Insurance Policy or these General Insurance Terms and Conditions when negotiating or changing the Insurance Policy, and lower Premiums were agreed as a result of such a breach, the Insurer has the right to reduce the benefit by an amount corresponding to the ratio of the Premium which the Insurer received to the Premium which the Insurer should have received.
2. If the breach of obligations by the Policyholder, the Insured or other person entitled to the benefit significantly affected the occurrence or progress of the Insured Event, caused an increase in the scope of its consequences or affected the determination of the amount of the benefit, the Insurer may reduce the benefit in proportion to the influence of the breach on the extent of the Insurer's obligation to pay the benefit. This also applies in cases in which the breach of obligations made it impossible to submit evidence of the Insured Event pursuant to these General Insurance Terms and Conditions.
3. The Insurer may withdraw from the Insurance Policy pursuant to Article 5(10) of the General Insurance Terms and Conditions or refuse to pay the benefit under the Insurance Policy pursuant to Article 14(1) of the General Insurance Terms and Conditions. The Insurance Policy may thus be withdrawn from even after the occurrence of an Insured Event.
4. If the Policyholder or the Insured knowingly provides untruthful or grossly distorted important information relating to the extent of the notified Loss Event, or if the Policyholder or the Insured knowingly conceals information relating to such an event, the Insurer is entitled to the reimbursement of the costs incurred in connection with the investigation of the facts with respect to which such information was communicated or concealed. It is understood that the Insurer incurred the costs in the documented amount effectively.

Article 19 Right of the Insurer to Learn and Review Information about the Policyholder and the Insured

1. The Insurer is entitled to learn and review any necessary information about the Policyholder and the Insured in connection with the Insurance. The Policyholder and the Insured are obliged to truthfully and completely answer any written questions of the Insurer relating to the arranged Insurance, changes in the Insurance Policy or any Loss Event.
2. The Insurer is entitled to request information about the state of health of the Insured and to ascertain the state of health or the cause of death of the Insured. The state of health or the cause of death is ascertained on the basis of reports and medical records requested by a medical facility authorised by the Insurer from the attending physicians, if necessary also on the basis of an examination carried out by a medical facility.
3. By signing the Insurance Policy, the Policyholder and the Insured agree that the Insurer may learn information about the health condition or the cause of death of the Insured if it is necessary for the arranged type of Insurance, and the Policyholder and the Insured exempt the physicians and employees of medical facilities, authorities and insurance companies by whom the Policyholder and the Insured were, are and will be treated, registered or insured from the confidentiality obligation, and empower them to provide any information necessary to the Insurer.
4. The Insurer is further entitled to learn information about and review the work and extra-work activities of the Insured (extra-work activities include sports or other leisure activities). The Insurer is further entitled to review any answers of the Policyholder and the Insured to the written questions of the Insurer.

Part II. Final Provisions

Article 20 Fees

Preparation of termination of the Insurance Policy within 2 months of the conclusion of Insurance	40% of the unused Premium
Issue of a copy of the Policy / the current status of the Insurance Policy from the system	CZK 50
Issue of a copy of the draft / Insurance Policy from the external archive	CZK 100
Issue of a confirmation of the Premium payment (on request)	CZK 50
Termination of Insurance in the event of expiry of the Insurable Interest	40% of the unused Premium

Article 21 Legal Acts, Serving of Documents

1. All communication of the Policyholder or the Insured must be sent to the address of the Insurer in writing. The Representatives of the Insurer are entitled to accept the communication; however, any communication shall be deemed delivered only at the moment the Insurer receives it.
2. Documents of the Insurer intended for the Policyholder or the Insured are generally served by a postal licence holder. Documents may also be delivered by the Representative of the Insurer to the address of the Policyholder or the Insured last known to the Insurer.
3. It is understood that a consignment sent by the postal service is delivered on the third business day following dispatch or on the fifteenth business day following dispatch if sent to an address in a different country.

4. If the Policyholder or the Insured refuses to accept the document without any reason, the document shall be deemed delivered on the day on which it was rejected by the Policyholder or the Insured.
5. If the Policyholder or the Insured is not reached and the Insurer's document is deposited at the post office or at the local municipal authority, the document shall be deemed delivered on the last day of its deposit period, even in cases where the Policyholder or the Insured do not know about the deposit of such a document.
6. If the Policyholder or the Insured fails to fulfil the obligation under Article 17(2)a) of the General Insurance Terms and Conditions and does not communicate his/her new address to the Insurer, the document shall be deemed delivered on the day on which it is returned to the Insurer as undeliverable.

Article 22 Final Provisions

1. It is allowed to depart from these General Insurance Terms and Conditions in the Insurance Policy should the purpose and nature of the Insurance so require.
2. The Czech version of the General Insurance Terms and Conditions and the contractual arrangements is considered to be the authentic version.
3. These General Insurance Terms and Conditions come into force and effect on 1. 9. 2017.
4. If the Insurance Policy has legal defects as a result of changes in general legislation or otherwise, such legal defects cannot cause the invalidity or ineffectiveness of the entire Insurance Policy. All the provisions of the Insurance Policy are severable, and if any provision becomes invalid, unlawful or contrary to the public interest, the validity of the remaining provisions will not be affected and the Insurance Policy will be considered as if it never contained such invalid provisions. In place of any invalid or ineffective arrangements, the Parties undertake to agree on new provisions with a content allowing the achievement of the purpose of this Insurance Policy.
5. In case of extrajudicial negotiations of consumer disputes concerning life insurance policies, the competent authority is the Financial Arbitrator at Legerova 1581/69, 110 00, Prague 1, www.finarbitr.cz. Concerning other insurance sectors, the competent authority is the Czech Trade Inspection Authority at Štěpánská 567/15, 120 00, Prague 2, www.coi.cz.

Part III. Definitions of Terms

Assistance Service is a service provided to the Insured in connection with the arranged Insurance, and is provided by a contractual partner of the Insurer. Current Premium is the Premium for the agreed Insurance Period.

Waiting Period is the period during which the Insurer is not obliged to provide any benefit for events that would otherwise be Insured Events.

Commuting to Work is the regular commuting of the Insured for the purpose of work outside the Czech Republic. Single Premium is the Premium determined for the entire period for which the Insurance has been arranged. Fortuitous Event is an event which is possible and could possibly occur during the term of the Insurance or whose time of occurrence is not known.

Beneficiary is a person designated by the Policyholder who becomes entitled to the benefit as a result of an Insured Event in the event of death of the Insured.

Entitled Person is a person who becomes entitled to the benefit as a result of an Insured Event. Premium Payer is a person who, under an agreement with the Policyholder, fulfils the obligation to pay the Premium or a proportion thereof; this does not affect the responsibility of the Policyholder for the Premium payment. Insurer is ERGO pojišťovna, a.s., Company ID No. 618 58 714, which is authorised to pursue insurance activities under special legislation.

Policy is a written document issued by the Insurer serving as confirmation of the conclusion of the Insurance Policy in the specified scope.

Insured Amount is the amount stipulated in the Insurance Policy constituting the maximum possible amount of the benefit payable by the Insurer upon the fulfilment of the conditions and circumstances specified in the Insurance Policy.

Term of Insurance is the period for which the Insurance is arranged.

Insurance Coverage is the overall scope of coverage agreed in the Insurance Policy.

Insured Event is a fortuitous event which is, under the provisions of the Insurance Policy, associated with the establishment of the Insurer's obligation to pay the benefit.

Premium is the payment for the agreed Insurance.

Peril is the possible cause of an Insured Event.

Insurance Period is the period agreed in the Insurance Policy for which the Current Premium is paid. Insurance Risk is the degree of probability of the occurrence of an Insured Event caused by a peril.

Policyholder is a person who entered into an Insurance Policy with the Insurer and is obliged to pay the Premium. Insurance Year is the period from the date of the commencement of Insurance to the next anniversary of the commencement of Insurance.

Insurable Interest is a legitimate need for protection against the consequences of an Insured Event.

Insured Person/Insured is a person to whose life, health, property or liability or other value of the Insurable Interest the Insurance applies.

Insurance is the commitment of the Insurer confirmed with the Policyholder in the Insurance Policy in which the Insurer agrees to provide the Policyholder or a third party with the benefit if an Insured Event occurs, and the Policyholder agrees to pay the Premium to the Insurer for the Insurance Coverage provided.

Capitalised Insurance is Insurance the purpose of which is, if an Insured Event occurs, the provision of a one-off or repeated benefit in the agreed amount, where the basis for determining the amount of the Premium and for calculating the benefit is the amount specified in the Insurance Policy which the Insurer is to pay if an Insured Event occurs, or the amount and frequency of payment of the pension.

Loss Insurance is Insurance to compensate for the loss of property arising from an Insured Event, in the agreed scope.

Repatriation is the medical transport of the Insured or his/her remains to their home country or to another country where the Insured is permitted to reside.

Other countries of the Schengen Area include Belgium, Denmark, Estonia, Finland, France, Iceland, Italy, Lithuania, Latvia, Luxembourg, Hungary, Malta, Germany, the Netherlands, Norway, Poland, Portugal, Austria, Greece, Slovakia, Slovenia, Spain, Sweden and Switzerland.

Loss Event is an event which caused a loss and which could give rise to the right to a benefit.

Accident means an unexpected and sudden impact of external forces or one's own physical force independent of the will of the Insured, or an unexpected and uninterrupted impact of high or low temperatures, gases, vapours, electricity and poisons (with the exception of microbial toxins and immunotoxic substances) which occurred during the term of the Insurance and which caused bodily harm or death to the Insured.

Anniversary Date of Insurance means the date which coincides (in the day and month) with the date specified in the Insurance Policy as the commencement of the Insurance (hereinafter also the "Anniversary of the Commencement of Insurance"). If there is no such day in the relevant month, the Anniversary Date will fall on the last day in the month.

Representative of the Insurer is a person authorised to act on behalf of the Insurer.

Contractual arrangements for health insurance for foreigners in the Welcome Standard policy

These contractual arrangements form an integral part of the Insurance Policy for health insurance for foreigners. The general principles of health insurance for foreigners arranged by ERGO pojišťovna, a.s. are set out in the General Insurance Terms and Conditions for Health Insurance for Foreigners - Welcome 170901 (hereinafter the "General Insurance Terms and Conditions").

By way of derogation from Article 10(1) of the General Insurance Terms and Conditions, Insurance in the Welcome Standard policy is agreed in the scope of "necessary and urgent health care", not in the scope of "comprehensive health care".

1. By way of derogation from Article 10(9) of the General Insurance Terms and Conditions, it is agreed that the total benefit per one Insured Event is limited to the amount of EUR 60,000. This amount constitutes the limit and may not be exceeded in the sum of the individual costs of medical care, including potential repatriation.
2. The Insurance does not cover the costs of treating illnesses which are treatable with over-the-counter medication and aids.
3. The Insurance does not cover the costs of outpatient prescription medication.
4. By way of derogation from Article 10(4)j) of the General Insurance Terms and Conditions, the Insurance does not cover follow-up medical examinations.
5. The Insurance does not cover health care pursuant to Article 10(5) and Article 10(6) of the General Insurance Terms and Conditions with the exception of necessary treatment in the case of a potentially fatal allergic reaction if it is the first occurrence of the given type of allergy in the Insured Person.
6. The Assistance Services pursuant to Article 11 of the General Insurance Terms and Conditions are only provided to the Insured Person if the costs of the treatment of the Insured Person exceed CZK 5,000 or the equivalent in a foreign currency. If the costs of the treatment of the Insured Person are lower than CZK 5,000 and the Insured Person decides to use the Assistance Services all the same, the Insured Person is obliged to pay the costs incurred by the Insurer in connection with the provision of the Assistance Services, but no less than CZK 1,500. The Insurer or the Assistance Service may deduct such costs from the benefit.

Contractual arrangements for health insurance for foreigners in the Welcome Plus policy

These contractual arrangements form an integral part of the Insurance Policy for health insurance for foreigners. The general principles of health insurance for foreigners arranged by ERGO pojišťovna, a.s. are set out in the General Insurance Terms and Conditions for Health Insurance for Foreigners - Welcome 170901 (hereinafter the "General Insurance Terms and Conditions").

By way of derogation from Article 10(1) of the General Insurance Terms and Conditions, Insurance in the Welcome Standard policy is agreed in the scope of "necessary and urgent health care", not in the scope of "comprehensive health care".

1. The Insurance does not cover health care pursuant to Article 10(5)a) of the General Insurance Terms and Conditions (regular outpatient care).
2. By way of derogation from Article 10(5)b) of the General Insurance Terms and Conditions, the Insurance does not cover follow-up allergy or immunological tests.
3. The Insurance does not cover health care pursuant to Article 10(5)c) of the General Insurance Terms and Conditions (pregnancy) with the exception of necessary treatment in cases in which the lives of the mother and the child are in danger due to pregnancy complications.
4. The Insurance does not cover health care pursuant to Article 10(5)d) of the General Insurance Terms and Conditions (dental care, except for post-accident dental treatment) unless the Insurance is arranged for at least one year.
5. The Insurance does not cover health care pursuant to Article 10(6) of the General Insurance Terms and Conditions (preventive care).

Contractual arrangements for health insurance for foreigners in the Welcome Baby policy

These contractual arrangements form an integral part of the Insurance Policy for health insurance for foreigners. The general principles of health insurance for foreigners arranged by ERGO pojišťovna, a.s. are set out in the General Insurance Terms and Conditions for Health Insurance for Foreigners - Welcome 170901 (hereinafter the "General Insurance Terms and Conditions").

The Insurance is arranged in the scope of "comprehensive health care" under Article 10 of the General Insurance Terms and Conditions.

1. The Waiting Period for pregnancy pursuant to Article 12(2) of the General Insurance Terms and Conditions does not apply to the Insurance arranged in this policy.
2. The Waiting Period for childbirth and subsequent post-natal care pursuant to Article 12(3) of the General Insurance Terms and Conditions does not apply to the Insurance arranged in this policy.
3. The scope of the Insurance in this policy extends to medical care for all newborn children of the Insured Person up to one month of age. This care is provided in the scope of "comprehensive health care" and means continuous post-childbirth hospitalisation, one preventive examination by a medical practitioner after discharge from hospital and mandatory vaccinations up to the limit of CZK 1,000.

Contractual arrangements for health insurance for foreigners in the Welcome Dítě+ (Child+) policy

These contractual arrangements form an integral part of the Insurance Policy for health insurance for foreigners. The general principles of health insurance for foreigners arranged by ERGO pojišťovna, a.s. are set out in the General Insurance Terms and Conditions for Health Insurance for Foreigners - Welcome 170901 (hereinafter the "General Insurance Terms and Conditions").

The Insurance is arranged in the scope of "comprehensive health care" under Article 10 of the General Insurance Terms and Conditions.

1. By way of derogation from Article 10(6) of the General Insurance Terms and Conditions, the Insurance covers all preventive examinations, including vaccinations at the general practitioner and dentist in a scope similar to the public health insurance of Czech citizens.

Informative overview of the scope of Insurance

	Comprehensive Health Care			Necessary and Urgent Health Care	
Welcome policy	Komplex	Baby	Dítě+ (Child+)	Standard	Plus
Overall limit per Insured Event	EUR 80,000	EUR 80,000	EUR 80,000	EUR 60,000	EUR 80,000
Medical transport	EUR 80,000	EUR 80,000	EUR 80,000	EUR 60,000	EUR 80,000
Repatriation of human remains	EUR 80,000	EUR 80,000	EUR 80,000	EUR 60,000	EUR 80,000
Dental treatment – accident	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000
Other types of dental treatment	CZK 6,000	CZK 6,000	CZK 6,000	no	CZK 6,000
Outpatient prescription medication	yes	yes	yes	no	yes
Treatment of illnesses treatable with OTC medications	yes	yes	yes	no	yes
Pregnancy, complications in pregnancy, childbirth	yes[1]	yes	no	no	no[2]
Newborn care	no	yes	no	no	no
Assistance Services	yes	yes	yes	yes[3]	yes
Preventive care, vaccinations	yes[4]	yes[4]	yes[5]	no	no
Regular outpatient care	yes	yes	yes	no	no

1 Waiting periods of 3 and 8 months apply to pregnancy and childbirth,

2 Does not apply to cases of acute danger to life,

3 Only in the case of treatment costing more than CZK 5,000,

4 Up to the limit pursuant to Article 10(6) of the General Insurance Terms and Conditions,

5 In a scope similar to the public health insurance in the Czech Republic