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 181201)

ERGO

Platnost od 01.12.2018

Health insurance for foreigners
(this version is only of an informative nature)

Information for applicants interested in negotiating an insurance policy (before concluding an insurance policy)

1. Information about the insurer

A) Commercial name and legal form of the insurer

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

B) Address of the insurer's registered office

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

C) Registration in the Commercial Register

Commercial Register maintained by the Municipal Court in Prague, Section B, Insert 2740

D) Name and registered office of the body responsible for supervising the activities of the insurer

Czech National Bank, registered office: Na Příkopě 28, 115 03 Prague 1

E) Contact information and manner of complaints handling

By telephone: +420 221 585 111
By e-mail: info@ergo.cz
By e-mail: stiznosti@ergo.cz
Website: www.ergo.cz
By letter: to the address of the registered office of the insurer
In person: at the address of the registered office of the insurer, branch (a list of branches can be found at www.ergo.cz)
The complaint may be submitted to the Czech Association of Insurance Companies or the Czech National Bank.
For potential out-of-court settlement of consumer disputes, for life insurance, the relevant body is the Financial Arbitrator, Legerova 1581/69, 110 00 Prague 1, www.finarbitr.cz, and in the other insurance sectors the Czech Trade Inspection Authority, Štěpánská 567/15, 120 00 Prague 2, www.coi.cz.

F) Language for communication between the Contracting Parties

Czech language

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

is available at www.ergo.cz in the About the Company / Legal Information section.

H) Contact information for the procedure for exercising a right to indemnification

By telephone: + 420 221 585 111
Web: www.ergo.cz

2. Information about obligation

A) Definition of health insurance for foreigners

The subject of the insurance are demonstrable costs associated with the stay of the insured party in the Czech Republic (hereinafter the "Czech Republic"), or his or her travel to other countries of the Schengen Area which arose in the context of medical expenses of the insured party due to his or her illness or injury, and costs associated with his or her repatriation. Act No. 89/2012 Coll., Civil Code, as amended (hereinafter the "CC"), other generally binding legal regulations of the Czech Republic, the General Insurance Terms for Health Insurance for Foreigners – WELCOME 181201 (hereinafter the "GIT"), the insurance policy and other potential arrangements apply for this insurance, which is negotiated by ERGO pojišťovna, a.s.

B) Who can be a policyholder

Only natural persons residing in the Czech Republic or legal entities that have their registered office or branch in the Czech Republic that the insurance concerns may conclude insurance as policyholders.

C) Non-insurable persons

Insurance may not be concluded by the following:

a) persons with severe nervous disorders – these include, in particular, those resulting in severe physical limitations or limitation of daily living and working activities. These disorders include, among others, stages of multiple sclerosis, amyotrophic lateral sclerosis (ALS), Morbus Parkinson, post-stroke condition with movement impairment, epilepsy, new tissue formation (tumours) in the central nervous system (CNS), polyneuropathy with movement impairment, severe brain or spinal cord injury with movement impairment, depression, bouts of unconsciousness and dizziness;
b) persons with mental illnesses - these include, in particular, manic depressive psychoses, schizophrenic and paranoid disorders, Morbus Alzheimer and other forms of dementia, psychoorganic syndrome, down syndrome, hydrocephalus, autism;

c) persons with the following diseases and restrictions: deafness (double-sided), blindness (both eyes), paralysis, drug or alcohol dependence and medicine addiction, liver cirrhosis, cancer, malignant tumours (carcinoma), TBC, kidney dialysis, HIV infection and AIDS.

D) Insurance coverage and territorial scope

The insurance can be agreed in the scope of "comprehensive medical care", which is provided in a scope similar to public health insurance, but with the agreed insurance exclusions and with the agreed indemnification limits. Therefore, the insurance does not ensure payment in the scope of, or in the amount that would be paid from public health insurance, and it is not identical to sickness insurance pursuant to Section 2847 et seq., CC. The insurance can also be agreed in the scope of "necessary and urgent" medical care. The territorial scope of the insurance is specified in detail in Article 3, GIT.

E) Exclusions from insurance

The insurance does not provide indemnification for: treatment of illnesses, injuries and other groups of diagnoses that existed before the beginning of the insurance; medical care which is not reimbursed to citizens of the Czech Republic who participate in public health insurance pursuant to generally binding legal regulations; medical care that is provided to the insured party at a medical care facility that does not normally provide such care to citizens of the Czech Republic who participate in public health insurance pursuant to generally binding legal regulations, with the exception of acute life threats (e.g. some private clinics); costs for drugs that the insured party obtained without a medical prescription; costs for cosmetic treatment and its consequences, chiropractic treatments or therapies; manufacture and modification of prostheses, orthoses, glasses, contact lenses, hearing aids and similar aids; interruption of pregnancy if it is not a threat to the life or health of the woman or genetically defective foetal development, i.e. in cases where the interruption of pregnancy is medically justifiable; treatment of infertility or sterility and artificial insemination; a medical procedure and its possible consequences if the insured party made a trip to Czech Republic or abroad for the purpose of undergoing this medical procedure; costs for treatment carried out by a relative of the insured party (e.g. husband, wife, parents); spa and sanatorium treatments and rehabilitation measures; treatment costs incurred as a result of a treatment application that is not considered lege artis by the professional medical community; treatment of illnesses, accidents and their consequences caused by war events or participation in mass protests, civil disobedience actions or other unrest; treatment of injuries resulting from the driving of motor vehicles without proper authorization (driver's license), if they occur outside the Czech Republic; transport or relocation using an air ambulance, unless the transportation is approved in advance by the assistance service; regulatory fees and surcharges; treatment in connection with committing a criminal offense and disorderly conduct that are considered misdemeanours if they occur outside the Czech Republic; treatment as a consequence of suicide or attempted suicide if it occurs outside of the Czech Republic; for deliberately caused illnesses and injuries if they occur outside the Czech Republic; accidents that occurred under the influence of alcohol, drugs or other psychotropic substances if they occur outside of the Czech Republic.

Indemnification is not provided if the insured party refuses to undergo repatriation, treatment, or necessary medical examination by a doctor appointed by the insurer or assistant service provider of the insurer.

Indemnification is not provided for injuries that occur during parachuting and paragliding, jumps with a parachute from heights, use of gliders, motor hang-gliders, ultralight aircraft, shuttles, bungee-jumping, flying in balloons, hovercrafts; the insurance shall not cover injuries occurring in the course of the service of pilots, other crew members and persons engaged in service activities using aircraft; the insurance also does not cover diving including decompression, mountain climbing, rock climbing, ice climbing and waterfall climbing, rafting, canoeing on a wild river, canoeing, ski mountaineering, skiing outside marked trails, motocross and motorcycle races, karate, taekwondo, aikido, kung-fu, judo, box, kick-boxing, etc.

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

In the Welcome Komplex tariff, a waiting period of three months from the beginning of the insurance applies to medical care related to pregnancy, and a waiting period of eight months from the beginning of the insurance for childbirth and subsequent medical care, i.e. that the insured loss is not the pregnancy of the insured party and the care associated therewith, which undeniably arose before the expiry of the third month of insurance period, and a birth which occurred before the end of the eighth month of the insurance period and the subsequent postnatal care relating to the birth in question.

F) Duration of the insurance policy, insurance period

The insurance shall be established and terminated on the date and at the time specified in the insurance policy as the beginning and the end of the insurance, and for an insurance policy negotiated via a distance method, it is agreed that this shall only apply under the premise that the first premium was paid before the agreed beginning of the insurance and the insurance policy (offer) was accepted by the policyholder in the proposed scope upon the payment of the first premium. Otherwise, the insurance policy will not be concluded. The insurance policy is also considered insurance. The insurance is negotiated for a fixed term and ends on the date and time specified in the insurance policy as the end of the insurance. The insurance period is the same as the insured period for which insurance is negotiated. The insurance cannot be concluded with retroactive effect.
The minimum duration of the insurance in the Welcome Standard and Welcome Plus tariffs is 1 month, 4 months in the Welcome Komplex tariff and 12 months in the Welcome Baby and Welcome Dítě+ tariff.

G) Methods of terminating the insurance, withdrawal from the insurance policy

The insurance shall be terminated upon agreement between the policyholder and the insurer; upon the expiration of the insurance period; upon the termination of the insurance interest; upon the termination of the insured risk; upon the death of the insured party or upon the termination of the legal entity without a legal successor, and/or upon death or the termination of the policyholder pursuant to Article 7, paragraph 4, GIT; upon the expiration of three months as of the date the insurance policy is concluded, if

the consent of the insured party was not proven, if such consent is required pursuant to generally binding legal regulations; on the date of refusal of indemnification by the insurer pursuant to Article 5, paragraph 5, GIT.

The insurance may also be terminated via a notice by the insurer or the policyholder. The policyholder or the insurer may give notice to the insurance with an eight-day notice period within two months from the date the insurance policy is concluded, or with a one month notice period within three months from the date of the notification of an insured loss. The policyholder may further give notice to the insurance with an eight-day notice period if the insurer violated the principle of equal treatment for determining the amount of the premium or for calculating the indemnification amount; within one month of the date on which the policyholder received a notification on the transfer of the insurance portfolio or of a part thereof, or the transformation of the insurer; or within one month from the date of publication of a notice that the insurer's authorization to conduct insurance activities has been revoked. The insurer may give notice to the insurance policy with an eight-day notice period upon an increase to the insured risk in the scope and under the conditions specified in Article 5, paragraph 8, letters a) and b), GIT. The insurance shall also be terminated upon a withdrawal from the insurance policy with effect on the date the insurance policy is concluded. The policyholder may withdraw from the insurance policy:

a) without giving any reason within fourteen days from the date the insurance policy is concluded, or from the date when the insurance terms were communicated to the policyholder, if the insurance policy was concluded via a remote transaction or outside of the business premises of the insurer;
b) if, when negotiating the insurance policy or a change thereto, the insurer or its authorized representative provides, intentionally or negligently, false or incomplete answers to the written questions of the policyholder regarding the insurance. This right may be exercised by the policyholder within two months from the date the policyholder ascertained such a fact;
c) if the insurer had to be aware of the discrepancies between the insurance offered and the policyholder's requirements when concluding the insurance policy and did not notify the policyholder of them. The policyholder may exercise this right within two months from the date of learning about such a fact. The insurer may withdraw from the insurance policy if the policyholder or the insured party, when negotiating the insurance policy or a change thereto, the insurer or its authorized representative provides, intentionally or negligently, false or incomplete answers to the written questions of the insurer regarding the insurance, if the policyholder would not conclude the insurance policy if the questions were answered truthfully and completely. The insurer may exercise this right within two months from the date the insurer ascertained such a fact. A withdrawal by the policyholder must be made in writing and sent to the address of the insurer's registered office. The insurer shall be obliged to return the paid premium to the policyholder, immediately, at the latest within one month of the date of delivery of the withdrawal from the insurance policy, deducting what has already been covered by the insurance, and the policyholder, the insured party or the beneficiary shall be obliged, within the same time limit, to return to the insurer the amount of the indemnification paid which exceeds the amount of the premium paid. The right to withdraw from the insurance policy shall expire if it has not been used within the applicable time limit for the individual reasons for withdrawal as described above. The form for withdrawal from the insurance policy is available at www.ergo.cz in the Client Service section, or at the registered office or at a branch of the insurer.

H) Information about the premium amount and insurance coverage limits

The premium is consideration for the insurance provided by the insurer in the scope agreed to in the insurance policy. The premium shall be determined by the insurer pursuant to scope of the insurance chosen by the applicant negotiating the insurance policy and shall always be imparted to the applicant before concluding the insurance policy. The premium amount depends on the chosen tariff, the age of the insured party and on the scope of the insurance. The insurance coverage limits depend on the chosen scope of insurance protection, see the table on last pages of the GIT. The premium for health insurance for foreigners includes cost surcharges calculated as 45% of the premium.
The insurance coverage limits depend on the chosen scope of insurance protection, see the table on last pages of the GIT.

I) Payment methods and due date of the premium

The premium may only be agreed as a one-time premium. The one-time premium shall be due on the date of the beginning of the insurance. The policyholder shall be obliged to pay the premium for the entire insurance period at once when concluding the insurance policy. If the premium is paid via a financial institution, bank or postal service operator, the premium shall be paid on the date of the sending of the full amount to the relevant account of the insurer with a financial institution, or the payment of the full amount in cash to the insurer or person authorized to receive the premium on behalf of the insurer. The first premium can be paid in cash. The premium must be paid in domestic currency, unless otherwise agreed. A premium paid without or with the wrong variable symbol shall be considered unpaid.

J) Fees

The insurer does not invoice any special fees for the use of remote means of communication. The following fees are collected over and above the premium:

Preparation of notice to the insurance policy within 2 months from when the insurance is concluded	40% of the unused premium
Issuing of an insurance policy duplicate / current status of the policy from the system	50 CZK
Issuing a photocopy of a draft / policy from an external archive	100 CZK
Issuance of confirmation of payment of the premium (upon request)	50 CZK
Termination of the insurance in the event of the termination of insurance interest	40% of the unused premium

K) Applicable law for the insurance policy, resolving disputes

All insurance policies negotiated with ERGO pojišťovna, a.s. are governed by the legal order of the Czech Republic. The competent courts of the Czech Republic shall deal with resolving disputes. Those interested in concluding an insurance policy may, upon request receive additional information relating to health insurance for foreigners. If this concerns an insurance policy concluded via a remote transaction, the policyholder shall be entitled to receive the insurance terms in written form at any time during the course of the insurance policy.

L) Method of determining the indemnification amount

The method of determining the indemnification amount is damage-based or volume-based depending on the particular coverage, see the relevant GIT articles.

M) Consequences of breaching insurance obligations

The insurer informs about the wording of Article 18, GIT, on the consequences that arise from a breach of obligations pursuant to the insurance policy.

General Insurance Terms and Conditions for Health Insurance for Foreigners - WELCOME 181201

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Inception date 1.12.2018

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 181201 (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;
1.
    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. 12.2018.
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 181201 (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 181201 (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 of foreigners agreed in the Welcome Baby tariff

These contractual arrangements are an integral part of the foreigners' health insurance policy. The General Principles of Health Insurance for Foreigners, which are negotiated by ERGO pojišťovna, a. s., are set out in the General Insurance Terms for Health Insurance for Foreigners - Welcome 181201 (hereinafter the GIT).
The insurance covers all medical care that the insured party undergoes in connection with pregnancy and childbirth in the Czech Republic in a contractual facility of the insurer or other facility previously approved by the insurer. This care means all medical examinations that the insured party undergoes during pregnancy, childbirth, subsequent postpartum hospitalization, and the first subsequent gynaecological examination in a puerperium after discharge from the maternity hospital.

The insurance is agreed in the scope of "comprehensive medical care" pursuant to Article 10, GIT.

1. The insurance agreed to in this tariff does not include the waiting period for pregnancy pursuant to Article 12, paragraph 2, GIT.
2. The insurance agreed to in this tariff does not include the waiting period for childbirth and subsequent postnatal care pursuant to Article 12, paragraph 3, GIT.
3. The scope of insurance for this tariff is extended to medical care for all newly born children of the insured party up to one month of age with an indemnification limit of 300,000 CZK. This care is provided in the scope of "comprehensive medical care" and means continuous postpartum hospitalization, one preventive check-up with a GP after discharge from the maternity hospital and compulsory vaccinations up to a maximum limit of 1,000 CZK.

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 181201 (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	CZK 300,000	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