General Terms and Conditions of

TESTŐR

Term Life, Accident and Health Insurance (TÁSZF022)

Effective from: April 26, 2025

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Contents

The official language of this document is Hungarian. In the event of any inconsistency between the Hungarian version and the translated English version, the Hungarian version shall prevail.

General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance (TÁSZF022)

These general terms and conditions of TestŐr Term Life, Accident and Health Insurance (hereinafter: general conditions) as well as the related special policy conditions set out the standard terms and conditions for **TestŐr Term Life, Accident, and Health Insurance policies (hereinafter: insurance policy or policy)** offered by Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy has been concluded by reference to these general conditions and the applicable special conditions.

These general conditions shall be supplemented by the **special conditions** of the life, accident and health insurance products with coverage option selected by the policyholder and the insured on the insurance application form.

In matters not regulated by these general conditions or the special conditions (hereinafter jointly referred to as: policy conditions), the document entitled „Generali Biztosító Zrt.'s Customer Information and General Provisions Governing Insurance Policies" (hereinafter: Customer Information), which forms part of the insurance policy, the provisions of the **Hungarian Civil Code,** and the provisions of other **effective Hungarian legislation** shall be applied.

Provisions of the special conditions may derogate from those of the general conditions, in which cases of derogation the provisions of the special conditions shall prevail. In the event of discrepancy between the document titled 'Customer Information and General Provisions governing Insurance Policies' and the policy conditions, the provisions of the policy conditions shall prevail.

I. CONTENT OF THE INSURANCE POLICY

Under the insurance policy, the insurance company undertakes to provide coverage for the insured risks set forth in these general conditions and the applicable special conditions, and to pay the insurance benefits if an insured event occurs; the policyholder, in turn, undertakes to pay the insurance premium.

II. GENERAL PROVISIONS

II.1. Parties to the Insurance Policy (Insurance Company, Policyholder, Insured and Beneficiary)

II.1.1. **Insurance company** is a legal entity which, in consideration of the payment of insurance premium, provides insurance coverage against insured risks and undertakes the obligation to pay the insurance benefits set forth in the policy conditions.

II.1.2. The **Policyholder** is the party who takes out the insurance policy from the insurance company and agrees to pay insurance premiums. The policyholder may be a consumer or a person or organization who is not a consumer by definition of the law. Consumer shall mean any natural person acting for purposes which are outside his trade, business, or profession.

II.1.3. **The insured** is a natural person who is designated in the insurance policy as insured and whose life or health is covered under the insurance policy with respect to specific insured events.

The insurance policy may be taken out for one or more insured persons, on the understanding that if a policy has been taken out for one insured, no additional insured can be added to the coverage later.

II.1.4. If the policyholder and the insured are different persons, **the insurance policy may only be concluded, or the respective insurance coverage may only be modified if it is consented by the insured person in writing.**

II.1.5. If the policyholder and the insured are different persons, the policyholder is required to inform the insured of the legal statements he/she is delivered as well as of any modifications of the insurance policy.

II.1.6. **If the insured is a minor** and the insurance policy is concluded by a person other than the parent legally representing such minor, the insurance policy, including any and all amendments to policy sections which pertain to the insured minor, shall only be deemed valid if the approval of the Children and Youth Services is obtained.

The consent of the guardian authority is required even if the insured is a **person of legal age whose legal capacity has been partially limited** in respect of making legal statements relating to property, or **if the insured person is an incompetent adult.**

II.1.7. The insured may withdraw his/her consent to the conclusion of the insurance policy any time in a written notice. As a result, the insurance policy – or if several persons are insured under the policy, the coverage applicable to the particular insured, – shall terminate as of the end of the policy year, except if the insured enters the policy as the new policyholder.

II.1.8. **The insured may enter** the insurance policy **as a new policyholder.**

The insurance company is required to be sent written notification of the change of the policyholder.

If the insured enters the insurance policy as the policyholder, the liability for the payment of premiums due in the current payment period shall lie with the insured and the original policyholder jointly. The insured who enters the insurance policy as a policyholder is required to repay to the original policyholder all costs incurred by the original policyholder in connection with the insurance policy, including the insurance premium.

If the insured replaces the original policyholder in the insurance policy, he/she will assume all the related rights and obligations therewith.

II.1.9. If both the policyholder and the insured agree in writing, **a third party** can take the insurance policy over **as a new policyholder.**

The insurance company is required to be sent written notification of the change of the policyholder.

II.1.10. **Beneficiary** is the person entitled to receive the insurance benefits specified in the insurance policy.

a) The beneficiary of all **insurance benefits due in the life of the insured** shall be the insured himself/herself.
b) In the event of the **insured's death,** the beneficiary of the insurance benefits shall be the person named by the policyholder and the insured as the beneficiary, or in the absence thereof, the heir of the insured.

II.1.11. **Subject to the written consent of the particular insured, the policyholder may designate a beneficiary** with respect to such insured person or **may modify** the designation of the beneficiary **in a written statement addressed and delivered to the insurance company** in accordance with the provision set out in Clause II.1.10. b), at the time when the insurance application is completed or any time throughout the whole duration of the insurance policy in the same manner, provided that such designation or modification is communicated to the insurance company prior to the occurrence of an insured event.

II.1.12. **The designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.13. **If an insurance policy is concluded without the consent of the insured, the part of the insurance policy where the beneficiary is designated shall be null and void,** and the insured's heir(s) shall be the beneficiary(ies) of the insurance who shall be required to reimburse the insurance premiums and any other costs paid on the insurance policy to the policyholder.

II.1.14. **Unless** with respect to the particular insured **a beneficiary is specifically named** in the insurance policy, or **if the designation of the beneficiary has been repealed** (Clause II.1.12) or was invalid at the time of the insured event, **then** the beneficiary of the death benefit **shall be the heir(s) of the insured.**

II.2. Conclusion of the Insurance Policy

II.2.1. The insurance policy is concluded by **execution of a written agreement** by and between the policyholder and the insurance company.

II.2.2. Any insurance premium (or premium installment) paid by the policyholder prior to the conclusion of the insurance policy shall be deemed as an advance premium, which the insurance company will handle free of interest. If the insurance policy is concluded, the advance premium shall count in full against the insurance premium. If the insurance policy is not concluded, the insurance company shall refund the advance premium to the policyholder.

II.2.3. **Before approving the policyholder's insurance application, the insurance company will carry out underwriting,** and in that context it may put questions to the policyholder and the insured, order health check, require that the insured give a medical history statement or take a medical screening, or complete other declaration forms.

The insurance company shall be entitled to verify the data so obtained.

II.2.4. Declarations made by the policyholder/insured and their answers to the questions raised by the insurance company shall be integral parts of the insurance application.

II.2.5. The findings of the underwriting procedure will determine whether the insurance company approves or denies the insurance application. The insurance application will be accepted by the insurance company by delivering a certificate of coverage containing terms identical to or different from those specified on the insurance application (hereinafter: certificate of coverage), or by the insurance company's implicit conduct (tacit contract).

If the certificate of coverage is issued with terms identical to those specified on the insurance application, the insurance policy will be concluded as of such issue date.

II.2.6. If the **certificate of coverage is issued with terms which differ** from those on the insurance application, and **this difference is not contested by the policyholder without delay, or within a maximum of 15 days, the policy will take effect on the different terms** at the time when the certificate of coverage is issued.

If the policyholder rejects (contests to) the derogation within the above timeframe, the insurance policy shall not be concluded. **The insurance company shall warn the policyholder of any material derogation in writing at the time when the certificate of coverage is delivered.** In the absence of this warning, the policy will enter into force with the terms specified on the application.

II.2.7. **A consumer contract will be concluded – by the insurance company's implicit conduct – on the terms of the application, also if the insurance company fails to respond to the insurance application within fifteen (15) days of its receipt, or sixty (60) days if medical underwriting is required for the assessment of the application, provided that the application was made on the insurance company's own standard application form for the type of policy in question, upon receipt of the relevant statutory information, containing the premium rates applicable.** In that case, the insurance policy will be concluded on the day following the end of the underwriting period, with retroactive effect to the date when the insurance company was delivered the insurance application.

II.2.8. If a policy which is concluded without the express statement of the insurance company derogates in material terms from the standard insurance terms and conditions, the insurance company will have 15 days of the conclusion of the insurance policy to propose that it be modified according to the standard terms. **If the policyholder refuses the proposed modification** or fails to respond to it within 15 days, **the insurance company may terminate the policy giving a 30-day written notice within 15 days upon receipt of the notification of the refusal or modification.** (Subsequent termination of a contract concluded by implicit conduct [tacit contract]).

II.2.9. The policyholder is bound by the insurance application for 15 (fifteen) days – in the event of medical underwriting for 60 days – of the date of the application's submission.

II.3. Commencement of the Insurance Coverage, Waiting Period

II.3.1. Unless otherwise provided for in these policy conditions and if the policy is validly concluded, the **insurance coverage shall commence at 0.00 a.m. on the day following the day when the policyholder has paid the first premium to the insurance company,** but not earlier than 0.00 a.m. on the day following the day on which the contract is concluded. The parties may derogate from this provision in a separate agreement.

II.3.2. The insurance company shall **set out a waiting period** in the insurance policy, the duration of which shall be **6 (six) months from the conclusion of the insurance policy,** except when the parties agree to a shorter waiting period.

During the waiting period, the insurance coverage shall be partial, and it only applies to accidents and insured events in direct causal relationship with accidents.

II.4. Amendment of the Insurance Policy

II.4.1. **Policy amendments subject to underwriting**

II.4.1.1. The insurance company shall be **entitled to carry out underwriting** for any client request to modify the insurance policy during the policy term to increase the sums insured specified on the insurance policy or include new risks in the coverage (hereinafter: customer requests relating to the insurance policy) **or may reject any such request without giving reasons.**

II.4.1.2. Based on the findings of the underwriting procedure, the insurance company is entitled to approve or deny the request submitted with respect to the insurance policy. The insurance company shall **inform the policyholder** whether the request relating to the insurance policy has been fulfilled or rejected.

II.4.1.3. If the customer request relating to the insurance policy is approved, the **insurance coverage with respect to the particular insured risk** shall commence on the first anniversary date after all data and documents necessary for the assessment of the request have been received by the insurance company.

II.4.1.4. If the insurance company agrees to provide coverage against a new life or health insurance risk during the insurance policy's term, the **waiting period applicable to such new risk shall be 6 (six) months starting from the commencement of the insurance coverage applicable to the new risks,** unless the parties agree to a shorter waiting period.

II.4.2. The insurance company **may unilaterally terminate** the **accident cover of** the insurance policy concluded with life and/or health insurance covers in **writing with effect from the last day of the insurance period.** The insurance company must inform the policyholder of this at least 30 days before the last day of the insurance period. If the policyholder does not wish to maintain the insurance policy without the terminated covers, he/she is entitled to terminate the entire policy without a notice period, as of the last day of the insurance period. The cancellation must be notified to the insurance company in writing by the last day of the insurance period at the latest.

II.5. Termination of the Insurance Policy

II.5.1. **Unless otherwise provided for in the special conditions, the insurance coverage in respect of the particular insured person and therewith a part of the insurance policy will be terminated (partial termination) in any of the following cases:**

a) if the insured dies;
   - if the insurance does not cover the death of the particular insured, the insurance policy will terminate without a payout on the date of the death, and the excess premium will be refunded to the policyholder;
   - if the insurance covers the death of the insured, the insurance policy will terminate – subject to the provisions of the chapters (VI and VII) on exclusions and payment exemption – when the death benefit is paid out, or when the insurance claim is rejected in accordance with the policy conditions, and the insurance coverage of the particular insured will terminate with the insured's death;

b) if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, after the expiry of the 30-day notice period, in respect of the insured person concerned (Clause III.3.);

c) if the policyholder and the insured are different persons and the insured withdraws his/her written consent to the conclusion of the insurance policy with effect from the end of the current insurance period, except when the insured enters the insurance policy as a new policyholder;

d) if the insurance policy is terminated **by the policyholder in writing** with **thirty days' notice** with effect from the **last day of the insurance period,** in respect of the insured person concerned;

e) if the insurance policy is cancelled by the insurance company in writing and the policy covers only accident risks, the insurance policy – or if the policy has more than one insured persons, the coverage of the particular insured – will be terminated subject to a **30-day notice period, effective on the last day of the insurance period.**

If the insurance policy has only one insured person, the entire insurance policy will terminate upon the occurrence of any of the events listed above.

II.5.2. **The insurance policy and the insurance coverage terminates under any one of the following conditions (termination of the entire policy):**

a) if several persons were covered under the policy, after the death of an insured person if there are no other insured persons left in the policy,
b) at the end of the term specified in the insurance policy;
c) if the premiums are not paid, in accordance with Clause IV.3 of these general conditions;
d) if the insurance policy as a whole is terminated for convenience by the policyholder (Clause II.6);
e) if the insurance policy which includes a life insurance cover is terminated for cause (Clause II.7), on the workday following receipt of the termination notice by the insurance company;
f) upon the subsequent termination of the policy if it was concluded by implicit conduct (tacit contract) (Clause II.2.8);
g) if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, after the expiry of the 30-day notice period (Clause III.3.), provided that all insured persons are affected by the termination due to a change of material circumstances;
h) if the insurance policy is taken out for more than one insured person and all the insured persons withdraw their written consent to the conclusion of the insurance policy with effect from the end of the policy period, except when any of the insured persons enters the insurance policy as a new policyholder.
i) if the insurance policy is canceled by policyholder for cause after refusing to accept the modification in accordance with Clause II.4.2. of these general conditions.

II.6. Termination of the Insurance Policy for Convenience

II.6.1. The insurance policy – or if the policy is taken out to cover multiple insured persons, the insurance coverage applicable to the particular insured – may be cancelled **by the policyholder with a 30-day written notice with effect from the last day of the insurance period.**

II.6.2. An insurance policy with accident coverage only – or in respect of a policy taken out to cover multiple insured persons, the insurance coverage applicable to the particular insured – may be cancelled **by the insurance company with a 30-day written notice with effect from the last day of the insurance period.**

II.6.3. The insurance company may not terminate an insurance policy that includes a life and/or health insurance cover by giving notice of termination, except in the event of a significant increase in the insured risk.

II.6.4. **If an insurance policy is cancelled by the policyholder for convenience, the insurance company may not reinstate the insurance coverage; in other words, the insurance policy may not be reactivated.**

II.7. Special Termination Rules applicable to Life Insurance Contracts

II.7.1. A policyholder consumer may cancel an insurance policy taken out with life insurance coverage (as well) (save for the case of mortgage payment protection life insurance) **within 30 days after receiving** the certificate of coverage which is delivered to prove that the insurance has been concluded (hereinafter: first certificate of coverage) **in a written notice without giving reasons.**

II.7.2. Within thirty days of receipt of the policyholder's notice of cancellation, the insurance company shall settle any payments made by the policyholder in connection with the insurance policy, in such a way that the insurance company shall reimburse the policyholder for the full amount of the premium/part of the premium paid to the insurer.

II.7.3. **The policyholder cannot validly waive this statutory right to terminate the insurance policy.**

II.7.4. **If an insurance policy is terminated in this manner, the insurance company may not reinstate the insurance coverage; in other words, the insurance policy may not be reactivated.**

II.8. Geographical Limit of the Insurance Policy

The insurance provides worldwide coverage which means the whole world.

III. RIGHTS AND OBLIGATION OF PARTIES TO THE INSURANCE POLICY

III.1. The Policyholder's and Insurance Company's Rights and Obligations

III.1.1. Pursuant to the provisions of the policy conditions, the policyholder is required to pay the insurance premium and – unless otherwise set out in the policy conditions – is entitled to make legal statements required for the insurance policy.

III.1.2. Under the insurance policy, the insurance company is obliged to pay the insurance benefits defined in the policy conditions.

III.2. The Policyholder's and the Insured's Duty to Disclose Information and Notify Changes

The policyholder and the insured person/persons have a duty to disclose information and report changes.

III.2.1. The duty of the policyholder and the insured to communicate information

Pursuant to their duty to disclose information, when taking out the insurance or when filing an insurance claim under the insurance policy, the policyholder and the insured are required to disclose every matter known to them or that they know to be relevant to the insurance company's decision to accept the risk or assess the claim. By giving complete and true answers to the written questions of the insurance company, and by making true and accurate declarations on the standard forms of the insurance company and/or voice recordings, parties shall have complied with their obligation to provide information.

Subject to a consent from the insured person/persons, the insurance company may verify any disclosed information, and for that purpose it may raise further questions about the health, activities (occupation, job, sports activities, other) and life circumstances of the insured, or even require medical examinations and/or tests or a health check.

Attending medical tests or a health check shall not release the policyholder and the insured from their duty to disclose.

III.2.2. The duty of the policyholder and the insured to communicate change

The policyholder and the insured person(s) are equally bound by the duty to disclose information and notify changes; none of them shall be entitled to refer to any circumstance that either one had neglected to disclose or report to the insurance company though it must have known about it and should have disclosed or reported it.

While the insurance policy is in force, the policyholder and the insured (or insured parties) are required to notify the insurance company in writing of any change in any relevant condition stated on the insurance application or included in the insurance policy within 5 workdays following such change.

Relevant material circumstances shall be all circumstances which the insurance company raised questions about, and which the policyholder or the insured are required to disclose information about, including particularly the policyholder's and the insured's name, address, mailing address, as well as their email address if electronic communication has been selected, the insured's activities (e.g.: occupation, job, sports) and their change.

The insured is not required to communicate changes in his/her health or medical conditions to the insurance company.

III.3. The insurance company's right to terminate or amend the insurance policy if new, relevant material circumstances arise or if the insured risk significantly increases

III.3.1. **If the insurance company becomes aware of certain material circumstances or is advised of a change to material circumstances regarding the policy only after the policy has been concluded,** and **pursuant to the insurance company's assessment these circumstances bring about a considerable increase in the insured risk, within fifteen (15) days of gaining knowledge of the new circumstances the insurance company shall be entitled to propose that the policy be amended or that the policy** – or if there are multiple insured persons, the applicable insurance coverage – **be terminated by serving a thirty (30) day written cancellation notice.**

A considerable increase in the insurance risk shall include cases when had the insurance company known about the material circumstance, it would have applied surplus premium or exclusions during the underwriting, or it would have denied the coverage.

If the insurance company fails to exercise this right, the insurance policy shall remain in force on the original terms.

III.3.2. **If the policyholder does not accept the proposed modification** or does not respond to it within 15 days of its receipt, the insurance policy or the provisions proposed to be modified will terminate on the 30th day after notification of the proposal for modification was given, provided that the insurance company has advised the insured of this legal consequence when sending out the notification.

III.3.3. If the policy covers multiple insured persons and the considerable increase in the insured risk only applies to some of them, the insurance company may not exercise its rights set out in Clause III.3 with respect to the other insured persons.

IV. INSURANCE PREMIUM

IV.1. Determination of Insurance Premium, Entry Age of the Insured

IV.1.1. The insurance premium is received in consideration of the obligations undertaken by the insurance company. The insurance premium is required to be paid by the policyholder.

IV.1.2. The insurance premium shall be calculated pursuant to the insurance company's Premium Rates Regulations based on the **insured's age, medical conditions, activities** (e.g.: occupation, job, sports), as well as on the **policy term and the sum/sums insured.**

IV.1.3. At the time when the insurance policy is taken out, the insurance company shall determine the initial age of the insured by deducting the birth year of the insured from the year of the technical commencement of premium payment.

IV.2. Payment of the insurance premium (payment frequency, technical commencement of premium payment, due date of premium payment), definition of the policy period and policy anniversary

IV.2.1. **The insurance policy may be taken out with regular annual premium payment.** The regular **annual premium** applicable to the policy year **may be settled in monthly, quarterly, or semi-annual installments.** The insurance company may offer a premium discount for any payment frequency other than monthly payment. Postal remittance payment is not available. In case of a one-year insurance contract, only annual premium payment frequency can be selected.

IV.2.2. If the policyholder has applied for and been granted a discount which affect premium rates, and the conditions which allowed the policyholder to be eligible to the discount have changed or no longer exist (e.g.: change of premium payment frequency), the policyholder will no longer be eligible for the discount and will be required to pay the insurance premium determined with standard rates (without the discount). In such a case the premium determined without the discount becomes due when the insurance company first sends out the respective payment notice (invoice, postal remittance form) or first tries to collect the payment (direct debit).

IV.2.3. **The payment frequency (payment plan) is determined by the policyholder at the time when the insurance is applied for,** but he/she may request a change in the original payment plan any time during the policy term by submitting a standard change request form, with effect from the first day of the month following the month in which the change request is submitted.

IV.2.4. The **technical commencement** of the premium payment shall be the date designated as such on the insurance application and the certificate of coverage. This date, however, **may not be earlier than the first day of the month in which the insurance application is executed. That date shall also be the anniversary of the insurance.**

IV.2.5. The **policy period shall be one year,** each time starting on the policy anniversary and lasting for one year from then on (hereinafter: policy year).

IV.2.6. The first premium of the insurance policy is payable at the time specifically agreed by the parties or failing that at the date when the insurance policy is taken out; any other premium shall be due on the first day of the respective premium payment period (year, half-year, quarter, month) which it is payable for.

IV.2.7. The first premium covers the period from the commencement of the insurance coverage to the technical commencement of premium payment as well as the first premium payment period.

IV.2.8. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the insurance premium is credited to the account of the insurance company.

IV.3. Consequences of Premium Payment Default

IV.3.1. **If the policyholder fails to settle the regular insurance premium by the set due date, the insurance company will send the policyholder a written payment reminder with at least an additional thirty-day (30-day) deadline including advice on the legal consequences of payment default.**

If the policyholder fails to comply with his payment obligation within the additional period, the policy shall be terminated with effect to the date until premiums were paid, except if the insurance company forthwith moves to enforce its claim by judicial process.

IV.3.2. **If only a part of the due premium is paid, and the insurance company's request – made in accordance with the provisions on premium payment default – to the policyholder for payment of the sum owed proved unsuccessful, the policy shall remain in force with the same amount of coverage for a term to which the premium paid corresponds.**

IV.3.3. The policyholder may, within 6 months of the due date of the first unpaid insurance premium, request that the insurance policy which was terminated without a payout due to the payment default be reinstated (reactivation) provided that all unpaid insurance premiums have been settled. In that case, the insurance company shall be entitled to carry out a new underwriting procedure, and either grant the request or reject it without giving reasons.

IV.3.4. If an insured event occurs during the insurance coverage, the insurance company shall be entitled to reduce the amount of the insurance benefit(s) payable to the beneficiary by the amount of any premiums due and unpaid until the occurrence of such insured event.

IV.4. Annual Indexation

IV.4.1. General Provisions

a) The insurer adjusts the sum(s) insured and the insurance premium once a year to the change in the price level (hereinafter: annual indexation). Annual indexation may be applied as of the anniversary date of the insurance policy.
b) Annual indexation is based on the indices disclosed in the Consumer Price Index publication of the Hungarian Central Statistical Office.

c) Annual indexation is the % growth based on the product of monthly consumer price indices of 12 months preceding the fourth month before the policy anniversary (hereinafter: indexation rate). If the value so calculated is less than 5%, the indexation rate shall be at least 5%.
d) The insurance company will send notification of the new sum(s) insured and the annual insurance premium of the policy applicable to the subsequent policy year at least 2 months before the policy anniversary, within the framework of the annual indexation procedure. If the policyholder does not wish to make use of the amendment, he/she has the right to refuse the indexation offer in writing within 30 days of receiving the notice or, at his/her option, to terminate the contract in writing for the anniversary (before the anniversary) without retaining the notice period.
If the policyholder does not expressly reject the annual indexation, or terminate the contract within the 30-day time limit, the insurance policy will be amended with the increased sum insured and insurance premium as of the policy anniversary.
e) The insurance company shall issue a new certificate of coverage with the modified sum insured and insurance premium within 30 days of such change, save for the case when the insurance company has given notification of all changes of the insurance policy in the notification set out in Clause IV.4.1. d).

IV.4.2. Annual indexation of accident insurance

For the purposes of accident insurance policies, the term 'annual indexation' means the increase of the sum insured and the corresponding increase of the insurance premium to the same extent once a year.

IV.4.3. Annual indexation on life and health insurance

a) With respect to health and term life insurance, annual indexation means the increase of the sum insured and the according increase of the insurance premium once a year. The insurance company increases the sum insured taking into account the index rate. When determining the insurance premium applicable to the increased sum insured (premium increment), the insurance company shall take account of the insured's current age, current activities (e.g.: profession, job, sports) and the remaining duration of the insurance policy.
b) The insurance premium payable after the annual indexation is the total of the last insurance premium prior to the annual indexation and the amount of the premium increment determined pursuant to Clause IV.4.3. a) above.
c) When determining the annual indexation, the insurance premium may be increased to an extent larger than the increase of the sum insured due to the change of the insured's age.

V. INSURED EVENTS, INSURANCE BENEFITS, PAYMENT OF CLAIMS – PAYMENT CONDITIONS, OPTIONAL FORMS AND METHOD OF BENEFIT PAYMENT, NO CLAIMS BONUS, COMPLIMENTARY HEALTH CHECK-UP

V.1. Insured Events

For the purposes of insurance policies concluded pursuant to these General Conditions and the related Special Conditions, insured events shall be events defined as such in the Special Conditions.

V.2. Insurance Benefits

If any of the insured events defined in the special conditions occurs, the insurance company shall pay the insurance benefit specified in the special conditions to the designated beneficiary or beneficiaries.

The insurance company will only reimburse costs which are set out in the policy conditions. The costs incurred in connection with reporting an insurance claim are only reimbursed by the insurance company if the insurance company expressly undertakes this obligation in the special conditions.

V.3. Conditions for Payment of Insurance Claims

V.3.1. Means of Reporting an Insured Event, its Deadline

An insured event is required to be reported to the insurance company within 15 days of its occurrence.

Where the **above time limit is not observed,** the information required by the insurance company for the assessment of the insurance claim is not disclosed, or the insurance company is not allowed to verify the content of the disclosure, and as a result circumstances which are **material for the insurance company's benefit payment obligation** may not be revealed, the **insurance company may be relieved from benefit payment.**

V.3.2. Documents Required for the Payment of Insurance Claims

The insurance company may also require the submission of the following documents if they are necessary for the establishment of the legal ground of the claim or the amount of the claim:

V.3.2.1. **A duly completed standard insurance claim form made available by the insurance company.**

V.3.2.2. **The documents specified in the governing special conditions must also be submitted to the insurance company.**

V.3.2.3. **Documents suitable for the clarification of all the circumstances and consequences of the insured event** (a statement by the insured and/or any other person involved in the insured event about the circumstances of the insured event, the accident & injury report and resolution issued by the police, the employer, the school, or the passenger carrier company, experts' opinions in connection with the accident/consequences);

V.3.2.4. A standard form supplied by the insurance company and **completed by the insured's treating physician or the medical facility where the insured was treated, with medical information in connection with the insured event, the insured's medical conditions, and the insured's medical history;**

V.3.2.5. The insured's **medical documentation** produced in connection with the insured event and the insured's medical history: a copy of the medical file issued by a general practitioner, a company physician, or a physician supervising the insurance portfolio; documents produced during outpatient or inpatient care; and documents in proof of the administration of pharmaceuticals;

V.3.2.6. The **documents managed by the social insurance body** or another person or organization, **containing data regarding the insured with respect to the insured event or a circumstance leading to such an event** (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);

V.3.2.7. The insured's sports club membership card or of the **membership certificate relating to any sports activities** which may impact the insurance coverage, the official match report;

V.3.2.8. An official certificate in proof of the insured's date of birth;

V.3.2.9. The Insured or the Beneficiary is also entitled to prove his/her claim for the service with other documents in accordance with the general rules of proof in order to enforce his/her claim. Thus, for example, he/she is also entitled to submit a final decision in criminal proceedings and infringement proceedings to the insurer.

V.3.2.10. The payment of the insurance benefit may be subject to a medical examination – in such a case, the benefit shall not be payable until the insured allows for the medical examination to be carried out.

V.3.2.11. The insurance company may also require that all documents necessary for the assessment of the insurance claim but **produced in a foreign language** shall be **translated into Hungarian** at the cost of the claimant, and the **official translations** shall be submitted to the insurance company for decision making.

V.3.2.12. The insurance company may require that **original copies of such documents are presented** and that they are also submitted on any form of electronic media chosen by the customer;

V.3.2.13. The insurance company is entitled to obtain additional documents for the adjustment of the insurance claim if such documents are requested within 15 days of receipt of the insurance claim and the request is communicated to the customer.

V.3.3. Due Date of Insurance Payouts

V.3.3.1. The insurance company shall pay the claim no later than **on the 15th day following receipt of the insurance claim as well as the last document necessary for its assessment; documents necessary for the assessment of the claim are those which evidence the legal ground for and the amount of the insurance claim. The death benefit will be paid out only** after the due diligence of the policyholder and the beneficiary has been completed, provided that it is required pursuant to Act CXXXVI of 2017 on the Prevention and Combating of Money Laundering and Terrorist Financing. When documents are obtained, the insurance company is required to pass a decision about the claim within 120 days after receiving the insurance claim, and shall communicate the decision to the customer.

V.3.3.2. If the documents required by the insurance company are not submitted or are incomplete despite a reminder, the insurance company will assess the claim based on the documents available.

V.3.3.3. If the documents available do not prove to be sufficient for the assessment of the insurance claim, the insurance company may require a medical examination of the insured by a physician. If the insured fails to attend the medical examination, the insurance company shall be entitled to make a decision on the basis of the data available.

V.3.3.4. The costs of the medical examination shall be borne by the insurance company. Any costs incurred by the insured in relation to attending the medical examination shall be borne by the insured.

V.4. Optional Forms of Insurance Payouts, Method of Payment

A insurance company shall pay the insurance benefit by bank transfer. If the person entitled to receive the benefit payable under the insurance (beneficiary) requests that benefits be paid in a different way, the insurance company shall **pass on all costs which the insurance company incurs in relation to such payment method to the beneficiary and will reduce the amount of the benefit accordingly.**

V.5. No Claims Bonus

V.5.1. If the **insured person – or any one of the insured persons – covered under the insurance policy submits no insurance claims,** the insurance company will reward it with a **bonus payment** made to the policyholder recorded in the policy at the maturity date, within 90 days after the maturity of the policy.

V.5.2. **The bonus rate** shall be **20% of the premium paid for the whole duration of the insurance policy** for the given no-claims insured person.

V.5.3. **Conditions for Payment of the Bonus:**

a) the insurance policy is for a term of at least 10 years, and
b) all due premiums have been paid on the insurance policy, and
c) the policyholder never requested a decrease of the sum insured applicable to any of the insured persons, and never canceled any part of the insurance coverage throughout the whole duration of the insurance policy, and
d) the insured has been covered under the insurance policy from the inception date to the maturity date of such insurance policy, and
e) **no insurance claim was reported on the insured,** which means that **throughout the whole duration of the insurance policy, the insurance company was not required to pay out an insurance benefit** on any insurance coverage taken out to cover the insured, and **nor is an insurance claim currently being assessed.** If the assessment of insurance claim is ongoing, and the claim is denied, the bonus will be paid to the policyholder at the time when the insurance claim is denied.

V.5.4. If the insurance company has paid a no-claims bonus to the policyholder, and a grounded insurance claim is subsequently made within the limitation period in respect of the previously no-claims insured for which the insurance company is obliged to pay an insurance benefit, the insurance company is entitled to recover the no-claims bonus paid.

V.6. Complimentary Health Check-up

V.6.1. If the conditions set out in Clause V.6.3 are satisfied, the insurance company **will organize a complimentary health checkup for the insured person** covered under the insurance policy, taking account of the insured's age and ne- stones.

V.6.2. **Complimentary health check-ups shall be arranged every 5 years, after the 5th, 10th, 15th, etc. anniversary of the insurance policy, and the insured person may participate in the screening within 6 months of the particular insurance anniversary.**

V.6.3. **Conditions for participation in the complimentary health checkup program by any given insured person:**

a) the insurance policy is for a term of at least 10 years, and
b) all due premiums have been paid on the insurance policy, and

c) at the time of the conclusion of the insurance policy and throughout its duration, **at least** one of the following covers is included in the insurance policy:
   i) term life insurance cover with a sum insured of at least HUF 10 million, or
   ii) permanent partial disability insurance cover for a disability to an extent exceeding 39% with a sum insured of at least HUF 10 million, or
   iii) permanent partial disability insurance cover for a disability to an extent exceeding 69% with a sum insured of at least HUF 10 million, or
   iv) 40 critical illnesses insurance cover with a sum insured of at least HUF 5 million, or
   v) malignant tumor insurance cover with a sum insured of at least HUF 5 million, and
d) the insurance policy is not subject to termination on the insurance anniversary referred to in Clause V.6.2 of these General Conditions, which is the date on which the eligibility to the complimentary health checkup program is established.

For contracts where the sums insured of the cover – specified in Clause V.6.3. c) – is reached or exceeded as a result of the annual indexation (Clause IV.4), the insured shall not be eligible for the complimentary health checkup program.

VI. EXEMPTION OF THE INSURANCE COMPANY FROM PAYMENT OF BENEFITS

VI.1. Exemption of the Insurance Company from the Payment of Life, Accident, and Health Insurance Claims

VI.1.1. If the policyholder or the insured infringe their obligation to disclose the required information or to notify changes, the insurance company's obligation to pay the benefits shall not set in, unless the policyholder proves that any of the following circumstances exist:
a) the concealed or unreported circumstance was known to the insurance company at the time when the insurance policy was concluded, or
b) the policyholder and/or the insured infringed their duty to communicate changes, but the concealed or unreported circumstance has come to the knowledge of the insurance company during the policy term prior to the insured event, and the insurance company failed to exercise its rights set forth in Clause III.3. of these general conditions to amend or terminate the insurance policy within 15 days, or
c) the concealed or undisclosed circumstance did not contribute to the occurrence of the insured event.

VI.1.2. If an insurance claim is legally grounded, the insurance company's obligation to pay the insurance benefits for any insured risk – with the exception of accident insurance risks – shall set in even if the duty of disclosure was infringed, if five years have already passed since the inception of the policy, or since the policy's modification to add new risks to the coverage until the occurrence of the insured event.

With the exception of accident insurance risks, if the duty of disclosure is infringed, the five-year period specified herein shall commence on the day following the deadline defined for complying with the duty of disclosure.

VI.1.3. The verity of the circumstances listed must be evidenced by the party referring to them.

VI.2. In addition to the cases listed in Clause VI.1 above, the insurance company shall be exempted from the payment of life insurance benefits if:
a) the insured dies as a result of suicide within two years of the insurance policy's inception date, even if the insured was in an altered mental status when committing such act,
b) the insured dies as a result of or in a causal connection with a major crime willfully committed by the insured,
c) the insured died as a consequence of willful conduct by the beneficiary.

VI.3. In addition to the cases listed in Clause VI.1 above, the insurance company shall be exempted from the payment of health and accident insurance benefits if:
a) the insured died as a consequence of willful conduct by the beneficiary.
b) the insurance company proves that the loss or damage was caused unlawfully, by deliberate conduct or in gross negligence by the policyholder or the insured; or by a relative living in the same household with them, or a company member authorized for business management.

When an event underlying an insured event occurs, the insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care. The insured's refusal – in exercising the right of disposition to which he is entitled by virtue of law – to a medical procedure shall not constitute an infringement of the obligation to mitigate damages.

The insured must act as generally expected in the given situation to prevent the occurrence of an insured event. If the Insured fails to comply with this obligation, the Insurance Company will be exempt from the benefit payment.

VII. EVENTS EXCLUDED FROM INSURANCE COVERAGE

VII.1. Exclusions Applicable to Life, Accident and Health Insurance Covers

VII.1.1. The insurance does not cover events caused in whole or in part by:
a) ionizing radiation,
b) nuclear energy,
c) infection by HIV,
d) war, combat operations, hostile actions of foreign forces, civil disorders, coup d'état or attempted coup d'état, riots, civil war, revolution, rebellion, demonstrations, processions, labor acts, terrorist activities, work misbehavior, border conflicts, insurrection.

VII.1.2. For the purposes of these general conditions, terrorist activities shall in particular mean unlawful acts involving violence or the threat of violence which endanger human life, tangible or intangible assets or the infrastructure, in support of political, religious, ideological, ethnic purposes or which are intended to influence any government or to create fear and terror in the whole or a part of society, or which are suitable for the above.

VII.1.3. Notwithstanding the provisions set forth in Clause VII.1.1. d) of these general conditions, the insurance covers any injuries to the insured's health which results from his/her active participation in demonstrations, processions, or strike actions announced in advance and organized in accordance with the provisions of effective Hungarian regulations, provided that the insured has fully complied with his/her obligation to prevent and mitigate the damage.

VII.1.4. **The insurance company shall not be liable for events arising out of or caused in whole or in part by the events listed hereunder:**
- **a) such illness or pathological condition of the insured that has been proven to have existed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any disease that had been diagnosed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any illness that required treatment or medical control during this time period,**
- **b) any permanent impairment of the insured that had been diagnosed prior to the commencement of the coverage period.**

For the purposes of this paragraph, a congenital anomaly or acquired disability includes any degree of physical and/or mental disability.

VII.1.5. **The insurance does not cover the events which take place while the insurance policy is in force (during the coverage period), if**
- **a) the event occurred in relation to regular alcohol consumption, drug consumption, the administration of stupefying agents or pharmaceuticals by the Insured, unless the latter was administered as prescribed by the treating physician;**
- **b) the insured was verifiably under the influence of alcohol or drugs, stupefying agents, or medication at the time of the event, If a blood alcohol test was administered, for the purposes of this paragraph, the person is 'under the influence of alcohol' if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,**
- **c) the Insured was driving a motor vehicle without a valid vehicle registration certificate or without a valid driver's license required for driving such vehicle, while at the same time also committed other traffic violations;**
- **d) the insured was driving a motor vehicle under the influence of alcohol when the insured event occurred and at the same time also committed other traffic violations.**

VII.1.6. **The insurance company shall not be liable for events arising out of or caused in whole or in part by the events listed hereunder:**
- **a) psychological conditions, illnesses and/or (a) psychiatric and psychic diseases;**
- **b) bodily injury caused intentionally by the insured person to himself/herself, even if the insured person did it while he/she was in a state of altered level of consciousness.**

VII.2. Exclusions Applicable to Accident and Health Insurance Covers

VII.2.1. **With the exception of accident insurance risks, the insurance does not cover pregnancy and delivery if conception took place prior to the commencement of the insurance coverage. The insurance company considers conception to have taken place prior to the commencement of the insurance coverage, if the number of days between the commencement date and the expected delivery date recorded in the official supporting documentation (ex: Medical record of pregnancy booklet) is less than 285 days.**

VII.2.2. **The insurance does not cover cases of abortion, except for abortions carried out in order to preserve the health of the mother, to save her life, cases of abortion in the case of a developmental disorder of the foetus confirmed by an appropriate diagnostic test, or abortions in connection with a criminal offence.**

VII.2.3. **The insurance does not cover events caused in whole or in part by:**
- **a) artificial insemination (and any of its form),**
- **b) events related exclusively to treating infertility,**
- **c) events related to infertility treatment procedures for the purpose of health care services aimed at averting the consequences of surgical infertility for non-medical reasons or at restoring the original condition,**
- **d) sterilization,**
- **e) sex reassignment surgery,**
- **f) treatment for aesthetic purposes, cosmetic surgery, and its consequences,**
- **g) prosthodontic treatment.**

VII.2.4. **If the insured requires lifesaving intervention as a result of any of the events listed in Clauses VII.2.1., VII.2.2., and VII.2.3., the insurance will cover the events which are the result of the conditions requiring medical care.**

VII.2.5. **The insurance does not cover events caused in whole or in part by:**
- **a) hospital care that is not for the purpose of diagnosing a disease of the insured, or preventing further deterioration of his/her medical condition or restoring his/her health, in particular screening tests, a parent's stay at a hospital with his/her child, or the insured's stay at a hospital for the purpose of nursing a parent,**
- **b) period of incapacity, which is not relating to diagnosing a disease, or preventing a deteriorating condition of the insured or to the rehabilitation of the insured, particularly a period of incapacity related to taking screening tests, or a parent's, stepparent's or guardian's incapacity due to caring for a sick child,**
- **c) rehabilitation or nursing of chronic illnesses (especially geriatrics, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), excluding treatments which are for the purpose of diagnosing chronic illness, initiation of a therapy, the prevention of significant deterioration of acute conditions,**
- **d) treatment performed by a person who does not have medical certification and a permit to practice medicine,**

VII.2.6. **The insurance does not cover psychological conditions, mental and psychiatric disorders.**

VII.3. Exclusion of Sport Injuries

Under a policy taken out with Endorsement No. SPO02, both knees and ankles of the insured are excluded from the insurance coverage, unless the insurance claim is for bone fracture, including incomplete fracture.

VIII. MISCELLANEOUS PROVISIONS

VIII.1. Period of Limitation

The limitation period of claims enforceable under the insurance policy shall be 2 (two) years.

The limitation period will commence at the following points in time:
- a) if an insured event is not notified to the insurance company, then at the time when the insured event occurred,

b) if an insured event is notified to the insurance company, then on the day following the 15th day of the date when the last document was received by the insurance company,
c) if an insured event is notified to the insurance company and if the documents or information required by the insurance company are not submitted or disclosed, on the day following the deadline of the document submission or information provision set out by the insurance company, or in the absence of such a deadline, on the day following the 30th day of the issue date of the written communication served for that purpose.
d) in other cases, at the date when the claim falls due.

VIII.2. Loss or Destruction of the Certificate of Coverage

If the certificate of coverage gets lost or is destroyed, the insurance company shall, at the request of the policyholder, issue a new document with the same content as that of the effective certificate of coverage.

VIII.3. Disputes Resolution Procedure

If the customer disputes the position of the insurance company in connection with an insurance claim, he/she may request a review of the decision in writing. The review shall be carried out by the competent organizational unit of the insurance company within 30 days upon receipt of all documents/data necessary for the assessment of the request and the decision shall be communicated to the claimant.

IX. TERMS AND DEFINITIONS

IX.1. Accident

IX.1.1. For the purposes of these general conditions, **accident** is any one-time, external physical impact and/or chemical exposure which the insured suffers beyond his/her control or is unwillingly exposed to during the policy term, and as a result the insured suffers permanent physical or mental impairment (permanent disablement) or dies.

IX.1.2. For the purposes of these general conditions, **accident also includes:**
a) meningitis and/or encephalitis as a result of a tick bite, if the illness has been serologically demonstrated, and has appeared the earliest a minimum of 15 days after the commencement of the insurance coverage, or the latest a maximum of 15 days after its termination. The onset of the illness is the day when the insured has first turned to a physician in relation to the diagnosed meningitis and/or encephalitis.
b) rabies, if the illness has been diagnosed, and has appeared no sooner than 60 days after the effective date of the insurance coverage, and no later than 60 days after its termination. Beginning of the illness is considered to be the day when the insured has first turned to a physician in relation to the diagnosed rabies.
c) tetanus infection, if the illness has been diagnosed, and has appeared no sooner than a minimum of 20 days after the commencement of the coverage, or no later than a maximum of 20 days after the expiration of the coverage. Beginning of the illness is considered to be the day when the insured has turned to a physician in relation to the diagnosed tetanus infection.

IX.1.3. For the purposes of these general conditions, notwithstanding the provisions set out in Clause IX.1.2., **accident does not include:**
a) infection by infectious agents (bacteria, virus, protozoa) from human or animal primary-host (carrier) to a human body secondary-host (receiver) which infection occurred directly or indirectly (hereinafter together: transmission), not even in the event that the transmission occurred as result of an accidental physical cause, unless the special conditions stipulate this otherwise,
b) occupational disease (harm),
c) the insured's suicide or suicide attempt, even if it happened while the insured was in an altered mental status,
d) pathologic bone fractures, repeated (habitual) dislocation,
e) development of disc herniation, unless the disc herniation is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy disc,
f) development of abdominal hernia, unless the abdominal hernia is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy abdominal wall,
g) damage to the articular joints, tendons, other soft tissues, unless the damage is the result of a one-time, extreme, exterior, mechanical impact to an otherwise healthy joint.

IX.2. Road Accident

IX.2.1. For the purposes of these general conditions, the term **road accident** means any accident suffered by the insured where the insured was involved in the accident as a pedestrian, or the driver of or a passenger in a vehicle.

IX.2.2. For the purposes of these general conditions, **road accident does not include:**
a) non-vehicular pedestrian accidents where the accident was not caused by a vehicle in motion,
b) bicycle accidents where the accident was not caused by another vehicle or pedestrian,
c) vehicle passenger accidents, where the accident did not occur as a consequence of the motion or stop of the vehicle or of another vehicle.

IX.3. Illness

For the purposes of these general conditions, **illness** (disease) is any deviation from or interruption of the normal structure or function of the human body.

IX.4. Hospital

IX.4.1. For the purposes of these general conditions, hospital means medical facilities which provide in-patient care and operate under permanent medical attendance and control, recognized, and licensed by the professional supervision.

IX.4.2. For the purposes of these general conditions, **hospital does not mean** sanatoriums, rehabilitation centers, thermal or hydromineral establishments, psychiatric hospitals or psychiatric wards, geriatric nursing institutes, social homes, alcohol and drug detoxification institutions, nursing institutes, other "chronic" care facilities, and hospital departments providing the above services, even if they offer hospitalized in-patient care, provided that the insured receives services in line with the specialization of such department.

IX.5. Surgery and the List of Surgeries

IX.5.1. For the purposes of the present general terms and conditions, the term **surgery** shall refer to medical procedures which involve an incision of the integument and/or the mucous tissue for preserving health, healing diseases and injuries, and mitigating the consequences of the above, governed by the principle of medical practice.

IX.5.2. The insurance company classifies surgical procedures into categories (hereinafter: classification of surgeries). This categorization of surgical procedures with the applicable insurance benefit rates (hereinafter: List of Surgeries) is set out in Annex „A" to these General Conditions. All WHO-coded surgical procedures were assessed by the insurance company for surgical reimbursement, with surgical procedures not included in any of the groups in the Surgical List falling into the "non-covered" surgical reimbursement category 5 (e.g., diagnostic tests, procedures including histological sampling, cytology, injection-infusion treatments, physiotherapy, chemotherapy).

IX.6. Qualification of the insured's sports activities

IX.6.1. For the purposes of these conditions the insured shall qualify as a **professional athlete** if he/she entered employment or other work-related legal relation with a sports association, or is engaged in sports activities under a sports contract, or is licensed as a professional athlete by a foreign sports federation.

IX.6.2. For the purposes of these general conditions the insured shall qualify as a **competing athlete** (hereinafter: competing athlete) if he/she is engaged in sports activities as a non-professional athlete but he/she participates in competitions (championships, matches) irrespective of the nature of such competition (whether they are local, district, county, regional, national, international competitions, and whether they are friendly games or for a prize etc.).

For the purposes of these general conditions, a competing athlete can be a top competing athlete, and an athlete who competes at regional level, or an athlete who competes at local level:

a) the insured shall qualify as a **top competing athlete** if he/she enters international and national competitions,
b) the insured shall qualify as an athlete who **competes at regional level** if he/she enters competitions organized for participants from several counties, provided that he/she is not a top competing athlete,
c) the insured shall qualify as an **athlete who competes at local level** if he/she is not a top competing athlete or an athlete who competes at regional level.

IX.6.3. For the purposes of these general conditions the insured shall qualify as a recreational athlete if he/she does not perform sports activities as a professional athlete or a competitive athlete.

IX.7. Termination of Pregnancy due to a Medical Condition in the Foetus

If a foetus is medically likely to suffer from a serious disability or other health impairment and the termination of the pregnancy is carried out only for this reason, with the permission of the competent public authority.

X. POLICY PROVISIONS THAT SUBSTANTIALLY DIFFER FROM THE PROVISIONS OF THE HUNGARIAN CIVIL CODE OR STANDARD CONTRACTUAL PRACTICE

This chapter summarizes the provisions of the General Terms and Conditions of the TestŐr Term Life, Accident and Health Insurance which substantially differ from the respective provisions of Act V of 2013 on the Civil Code of Hungary, or from standard contractual practice.

X.1. Conclusion of the Insurance Policy

Within the meaning of Clause II.2.1 of these conditions, and by way of derogation from Section 6:443. (1) of the Civil Code, the insurance policy will be concluded pursuant to an agreement executed in writing by the policyholder and the insurance company.

Pursuant to Clause II.2.6 of these policy conditions, and by way of derogation from Section 6:443 (2) of the Civil Code, if the certificate of coverage is issued with terms which differ from those of the insurance application, this difference may be contested by the policyholder without delay, or within a maximum of 15 days.

X.2. Additional Payment Deadline, Reactivation Option

Pursuant to Clause IV.3.1 of these policy conditions, and by way of derogation from Section 6:449 (1) of the Civil Code, the insurance company will send the policyholder a written payment reminder with at least an additional thirty (30) day deadline if the policyholder fails to settle the insurance premium by the due date.

Pursuant to Clause IV.3.3. of these policy conditions, and by way of derogation from Section 6:449 (2) of the Civil Code, the policyholder may request – within 6 months – that an insurance policy which was terminated without a benefit payout due to missed premium payments should be reinstated.

X.3. Period of Limitation

The provision on the statute of limitations set out in Clause VIII.1 of these conditions differs from the five (5) year limitation period prescribed in Section 6:22 (1) of the Civil Code. The limitation period for claims arising under this policy shall be 2 (two) years.

Annex “A”

Classification of Surgical Procedures by Benefit Categories for TestŐr Term Life, Accident and Health Insurance (TÁSZF022)

Classification of Surgical Procedures by Benefit Categories for TestŐr Term Life, Accident and Health Insurance:

for surgeries in the 1st Category 100% of the sum insured,
- open surgeries involving the brain/spinal cord
- open heart surgeries
- organ transplantations

for surgeries in the 2nd Category 50% of the sum insured,
- head and neck surgeries (not including skin, mucous membrane and subcutaneous lesions) excluding thyroid, parathyroid, tracheostomy
- open thoracic surgeries (e.g., lung, mediastinum, oesophagus, lymph node surgeries), except cardiac surgeries
- coronary artery surgeries
- open surgeries on the thorax, abdominal aorta and vena cava

for surgeries in the 3rd Category 25% of the sum insured,
- thyroid, parathyroid surgeries
- operations on bones of the face and skull and inner ear
- endoscopic chest surgeries (e.g., thoracoscopic, mediastinoscopic, VATS)
- trans vascular cardiac, thoracic, abdominal aortic and vena cava surgeries
- open surgeries on large vessels from the aorta and vena cava
- abdominal, pelvic surgeries,except for infertility, pregnancy, childbirth and diagnostic purposes
- open surgeries on the spine
- major joint (shoulder, elbow, hip, knee) replacement surgeries
- limb amputations at the wrist, ankle, and their proximal height

for surgeries in the 4th Category 15% of the sum insured will be paid,
- endoscopic, punctios, drain surgeries and interventions involving the brain/spinal cord
- peripheral neurosurgery
- operations on the soft tissues of the face (e.g., external and middle ear, salivary glands, nose, paranasal sinuses, salivary glands, lymph nodes, tongue, nasal and pharyngeal tonsils)
- eye surgeries (except laser eye surgeries to improve vision)
- endoscopic (e.g., thoracoscopic, mediastinoscopic, VATS) – diagnostic thoracic procedures, with or without sampling
- heart pacemaker implantation
- pericardiocentesis - vascular catheterisation (e.g., stenting, dilatation)
- peripheral artery and vein surgery (including varicose vein surgery)
- chest wall and breast surgeries
- diagnostic abdominal, pelvic surgery with or without sampling
- abdominal operations
- surgeries on the external genital organs, urethra, and anus
- gynaecological curettage and operations on cervical lesions
- transurethral (TUR) prostate and bladder surgeries
- superficial lymphadenectomy
- endoscopic, therapeutic interventions (e.g., otoscopy, rhynoscopy, bronchoscopy, gastroscopy, colonoscopy, cystoscopy, ureteroscopy, colposcopy, hysteroscopy, etc.)
- percutaneous viscerostoma (body cavity stoma) surgeries
- micro (minimally invasive) surgeries of the spine
- arthroscopic and open joint surgeries (excluding joint replacements)
- non-groin joint replacement surgeries
- operations for bone (including ribs, sternum, pelvis, limbs) diseases, injuries, fractures (excluding amputations of limbs)
- surgeries for muscle and tendon diseases and injuries
- limb amputations distal to wrist, ankle
- tissue transplants (e.g., skin, cornea, bone, bone marrow, tendon, muscle, pancreas, stem cells), except blood products

surgeries in the 5th Category are not covered
- laser vision correction corneal surgery
- vascular catheterisation for diagnostic purposes
- treatment of injuries to the skin and mucous membranes and subcutaneous tissues (e.g., sutures, removal of nerve tissue)
- surgical removal of lesions of the skin, mucous membranes, and subcutaneous connective tissue (e.g., moles, warts, lipomas)
- removal of foreign bodies from open body cavities (e.g., alimentary canal, nose, trachea, bronchus, bladder, vagina) and from the eye
- endoscopic procedures (e.g., otoscopy, rhynoscopy, bronchoscopy, gastroscopy, colonoscopy, cystoscopy, ureteroscopy, colposcopy, hysteroscopy, etc.) for diagnostic purposes, with or without histological sampling
- arthroscopy for diagnostic purposes
- dental procedures
- procedures and surgeries for aesthetic purposes only
- procedures and surgeries related to infertility, pregnancy, childbirth
- percutaneous histological sampling, punctio, drain from any organ except the brain

Annex “B”

Permanent Health Impairment Rates

The table referred to in the special conditions of Accident Insurance with Permanent Disability Benefit and Road Accident Insurance with Permanent Disability Benefit for the determination of insurance benefits.

The purpose of this table is to illustrate the concept of how insurance benefits are determined.

The extent of the permanent impairment shall be determined by a physician assigned by the insurance company, in accordance with the following:

Body parts, sensory organs	**Health impairment rate %**
loss of an arm at shoulder joint, or its permanent loss of function	70%
loss of an arm above elbow joint, or its permanent loss of function	65%
loss of an arm below elbow joint, or loss of a hand, or its permanent loss of function	60%
loss of a thumb or its permanent loss of function	20%
loss of an index finger or its permanent loss of function	10%
loss amputation of any other finger or its permanent loss of function	5%
loss of a leg through the hip joint or the permanent loss of function of the hip joint	70%
partial dismemberment of one leg above knee joint or the permanent loss of function of the knee joint	60%
partial dismemberment of a leg below knee joint	50%
loss of the ankle joint, or its permanent loss of function	30%
loss of a great toe or its permanent loss of function	5%
loss of any other toe or its permanent loss of function	2%
complete loss of vision in both eyes	100%
complete loss of vision in one eye	35%
complete loss of vision in one eye, if the insured has already lost vision in the other eye prior to the occurrence of the insured event	65%
complete loss of hearing in both ears	60%
complete loss of hearing in one ear	15%
complete loss of hearing in one ear, if the insured has already lost hearing in the other ear before the occurrence of the insured event	45%
complete loss of smell	10%
complete loss of tasting	5%