General Terms and Conditions of Employer's Group Insurance (KMÁSF/02017)

Effective from: September 1, 2017

Form No.: 25169

Contents

General Terms and Conditions of Events Group Insurance (KRÁSF/02017)

These general terms and conditions of Employer's Group Insurance (hereinafter: General Conditions) as well as the related special policy conditions set out the standard terms and conditions for policies with life, accident and health insurance covers (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 benefits of the policyholder's choice specified on the insurance application form.

All matters not regulated by these General Conditions or the Special Conditions (hereinafter jointly referred to as: policy conditions), will be governed by the provisions of the **Hungarian Civil Code** or the provisions of other **effective Hungarian legislation.**

The provisions of the Special Conditions may derogate from the provisions set out herein, in which case 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 in the Special Conditions, and to pay 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

II.1.1. **Insurance company** is a legal entity which, in consideration of the payment of insurance premiums, provides coverage for the insured risks and undertakes the obligation to deliver covered services and pay insurance benefits set forth in the special insurance conditions.

II.1.2. **Policyholder** may be a **person or organization who is not a consumer** and takes out an insurance policy from the insurance company and agrees to pay insurance premiums. Consumer means any natural person acting for purposes which are outside his trade, business or profession.

II.1.3. The **insured** shall be a natural person who is employed by the policyholder, and whose life or health is covered under the insurance policy with respect to specific insured events. The policyholder can specify who are insured under the policy when completing the insurance application, but the policyholder may also request that new, additional insured persons be added to the insurance coverage after the insurance has been taken out.

II.1.4. The policyholder may define multiple insured groups for the policy concluded pursuant to these General Conditions, by name or by the number of members. Each insured group may contain insureds who are exposed to identical occupational risks and are eligible for identical insurance benefits. In terms of occupational risk, the insurance company shall differentiate between average and hazardous occupations. The list of hazardous occupations are contained in Schedule A of the general terms and conditions, which shall be an integral part of the insurance policy. Insured groups may only be defined on the basis of the job, place of work, or position in the organizational hierarchy. On the insurance application, the policyholder is required to clearly state the insured group based on the respective job, place of work, or position in the organizational hierarchy, and if possible to also indicate the place of operations.

II.1.5. **The validity of the provisions of the insurance policy applicable to an insured minor, including any and all amendments made thereto while the insured is a minor, shall not be subject to approval of the Children and Youth Services.**

The consent of the guardian authority is not required even if the insured is a person 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.1.6. **Beneficiary** is the person who is entitled to receive the insurance benefit. Subject to the written consent of the insured, the policyholder can designate a beneficiary in a written notice addressed and delivered to the insurance company. The designation may be withdrawn or modified (and a new beneficiary be named) in the same manner any time prior to the occurrence of an insured event. **Unless otherwise agreed and stipulated by the parties, under this policy the policyholder waives his right to designate a beneficiary to the insured person(s).**

II.1.7. The beneficiary of all insurance benefits due in the life of the insured shall be the insured himself/herself, or the person(s) so designated in the policy. If the insured dies, the beneficiary of the insurance proceeds shall be the person(s) designated in the policy or if no beneficiary has been designated, the heir(s) of the insured.

II.1.8. **The designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.9. A beneficiary may be designated and the designation may be modified at the time when the insurance is taken out and/or any time during the policy period prior to the occurrence of an insured event.

II.2. Conclusion of the insurance policy and the insurance coverage, modification of the policy

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

II.2.2. With respect to insured groups that are registered by **the number of group members,** and insured groups that are registered by **the names of group members** (Clause III.2.5.), the insurance coverage may be taken out without the insured's statements.

II.2.3. In the case of insured groups **defined by name and subject to medical underwriting** (see: Clause III.2.5.), an insured's statement is required to be completed and the medical underwriting procedure prescribed by the insurance company is required to be executed for the insurance coverage to commence validly.

II.2.4. The **insured's statement** is a document which contains the insured person's consent to the extension of the insurance coverage, information regarding the rights and obligations of the insured, particularly the exemption from confidentiality obligation with respect to certain authorities and institutions, and a beneficiary designation of the insured.

The insured's statement is an integral part of the policy.

II.2.5. The insured is required to complete all the prescribed statements with complete and true information. The questions raised by the insurance company and the answers given by the insured shall constitute a part of the insurance policy.

II.2.6. The insured may withdraw his/her insured's statement any time in writing. As a result of the withdrawal, the insurance coverage applicable to the particular insured shall terminate at 0 a.m. of the first day of the month following the day when the withdrawal has been received by the insurance company. **The insured may not replace the policyholder in the policy.**

II.2.7. Any insurance premium (or premium instalment) 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 is fully offset against the insurance premium.

If the insurance policy is not concluded, the insurance company shall refund the advance premium to the policyholder.

II.2.8. Before approving an insurance application or the extension/modification of the insurance coverage with respect to a particular insured, the insurance company is entitled to carry out **underwriting** and for that purpose it may require a medical history statement, a medical examination, health check or other written declarations from the insured. The insurance company may require the insured to complete a paper-based medical history statement form, or to make such statement over the phone at a prearranged point of time. If the medical history statement is given over the phone, the telephone conversation shall be recorded. The insurance company will have not more than 60 days to complete the medical underwriting. **The insurance company shall be entitled to verify the data so obtained.**

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.2.10. 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.2.11. The findings of the underwriting procedure will determine whether the insurance company approves or denies the insurance application or the coverage modification, or proposes an amendment.

The insurance company is not required to give reasons for the denial of the insurance application or the expansion/modification of the insurance coverage, or for any proposed amendments.

II.2.12. If the **certificate of coverage is issued with terms which differ from** the terms of the **insurance application** or in the case of a policy modification, they differ from the terms of the **modification proposal,** and **this difference is not contested** by the policyholder without delay, or **within a maximum of 15 days, the policy will take effect/will be modified on the different terms.**

If the policyholder rejects (contests to) the derogation, the insurance policy shall not be concluded or the amendment does not take effect. **The insurance company shall warn the policyholder in writing of any material derogation 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 or on the modification request.

II.2.13. **The insurance policy may be modified without the consent of the Insured.**

II.2.14. **The insurance policy is validly concluded if the insurance company approves the insurance application completed by the policyholder and delivers the respective policy documentation.**

II.2.15. **The policy shall be executed – 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.2.16. 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 30 days 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.3. Commencement and termination of coverage, waiting period, and insurance anniversary

II.3.1. Unless the parties agree otherwise, if the insurance policy is validly concluded, the coverage applicable to the **insured persons specified on the insurance application** will commence at the following points of time:

a) with respect to **insured groups defined by the number of members or by name** and not subject to medical underwriting, the insurance coverage shall commence at the date specified on the insurance application, provided that the policyholder has paid the insurance premium to the insurance company,

b) with respect to **insured groups defined by name and subject to medical underwriting,** the insurance coverage – applicable to the particular insureds – shall commence at 0 a.m. of the day following the day when the underwriting with respect to the given insured person is completed, provided that the insurance company has accepted the risk and the policyholder has paid the insurance premium to the insurance company. The insurance company will communicate the commencement of the coverage with respect to each insured person, to the policyholder.

II.3.2. Unless the parties agree otherwise, if the policyholder **applies for additional insured persons to be added to the insurance coverage** after the conclusion of the insurance policy, the insurance coverage with respect to such insured persons will commence at the following points of time:

a) with respect to a new insured person to be added to an **insured group defined by the number of members** (III.2.9.), the coverage shall commence at 0 a.m. of the first day of the employment, and in other cases at 0 a.m. of the day following the date of the notice given,
b) with respect to a new insured person to be added to an **insured group defined by names** and not subject to medical underwriting (III.2.8), the coverage shall commence at 0 a.m. of the day following the date when the notification of change has been received by the insurance company,
c) with respect to a new insured person to be added to an **insured group defined by names** and subject to medical underwriting (III.2.8), the coverage shall commence at 0 a.m. of the day following the date when the medical underwriting is completed, provided that the insurance company has accepted the risk. The insurance company will communicate the commencement of the coverage with respect to each insured person, to the policyholder.

II.3.3. **With respect to the particular insured persons, the insurance coverage will terminate in the following cases:**

a) if the insured dies, at the time of the death,
b) if the policy is cancelled by the parties in accordance with Clause II.5.2 and if it is cancelled by the insurance company in accordance with Clause III.3,
c) if the coverage took effect subject to the insured's statement, and the insured withdraws the statement, the coverage terminates at 0 a.m. of the first day of the month following the day when the withdrawal has been received by the insurance company,
d) with respect to a departing insured (III.2.8), the coverage terminates at 0 a.m. on the first day of the month following the date when the notification on the (III.2.7) cessation of the insured's eligible for coverage is received by the insurance company,
e) if termination is initiated by the policyholder in writing, the coverage terminates at 0 a.m. on the first day of the month following the date when the notification is received by the insurance company,
f) in other cases and in the manner set forth in the Special Conditions.

II.3.4. The **insurance anniversary** shall be the first day of the month following the month in which the insurance coverage commences according to the insurance application.

If the commencement of the coverage is the first day of any month, that date shall also be the date of the insurance anniversary.
The parties may agree to derogate from the provisions stipulated herein, subject to their mutual consent.

II.3.5. The insurance company **may set out a waiting period** of no longer than six (6) months (hereinafter: waiting period), the first day of which shall be the commencement of the coverage pertaining to the insured.

If a waiting period is set out, the insurance company will inform the policyholder thereof in an endorsement to the policy.

During **the waiting period the insurance coverage shall be partial,** and it will only apply to accidents and insured events in direct causal relationship with accidents, provided that the insurance policy otherwise covers these risks.

II.4. Policy Period

This insurance policy is concluded for an indeterminate period of time.

II.5. Termination of the insurance policy

II.5.1. **The policy shall terminate:**

a) if the insurance premium is not paid by the due date specified in Clause IV.5.2;
b) if the policyholder entity is terminated without legal succession, at the date of its termination,
c) in the event of the subsequent termination of a policy concluded by implicit conduct (tacit policy) (Clause II.2.16), or if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, at the end of a 30-day notice period (Clause III.3),
d) if cancelled by the policyholder or **the insurance company.**

II.5.2. **The policyholder and the insurance company may terminate the insurance policy in a written notice delivered at least 30 days before the end of the policy year with effect from the insurance anniversary.**

II.6. Geographical Limit

Unless otherwise provided for in the Special Conditions, the insurance provides worldwide coverage which means the whole world.

III. RIGHTS AND OBLIGATIONS OF THE PARTIES TO THE INSURANCE POLICY

III.1. Rights and Obligations of the Parties to the Insurance Policy

III.1.1. The **policyholder is required to inform** the insured persons of the content of the policy conditions and of any amendments made thereto.

III.1.2. The policyholder may request the modification of the policy. The insurance company may approve or deny the proposed modification or may propose an amendment thereof. The insurance company is not required to give reasons for the denial or for the proposed amendments.

III.2. The Policyholder's and Insured's Duty to Disclose and Communicate Change

III.2.1. The policyholder and the insured are required to comply with their obligation to disclose information and notify changes.

III.2.2. The **duty to disclose information** means that the policyholder and the insured are required to declare to the insurance company all circumstances which may be relevant for underwriting purposes, for policy modifications or for claim settlement, and which they were or must have been aware of. The parties are bound by this obligation when the insurance is taken out, and throughout the whole policy period. Parties have complied with their obligation to provide information if they answer all questions asked by the insurance company, provided that such answers are complete, true and accurate.

III.2.3. Subject to the insured's consent, the insurance company may verify any disclosed information, and for that purpose it may raise further questions about the health, profession and life circumstances of the insured, or even require medical tests or a health check.

III.2.4. Attending medical examination or a health check shall not release the policyholder and the insured from their duty of disclosure.

III.2.5. Under any one policy, different methods may be applied to **defining insured groups.**

Depending on the method of record-keeping, the policyholder is required to provide the following information about the insured members of different insured groups when completing the insurance application:

a) where an **insured group is defined by the number of group members,** the number of the members as well as their jobs,
b) if an **insured group is defined by the name of group members** without medical underwriting, the name, place and date of birth, gender, permanent address and job of each insured in the group,
c) if an **insured group is defined by the name of group members** with medical underwriting, the name, place and date of birth, gender, permanent address and job of each insured in the insured group. Moreover, the policyholder is required to obtain the insureds' statements and medical history statements, where applicable.

III.2.6. At the request of the insurance company, the policyholder is required to provide a list of the insured persons in an insured group defined by the number of members, any time during the policy period.

III.2.7. The **duty to notify changes means** that during the coverage period the policyholder and the insured are required to give **written notification** of any change in any relevant condition which have been disclosed on the insurance application or on the insured's statement or which have been specified in the policy, **within 5 workdays** following such change.

Relevant condition shall be everything that the insurance company has required to be stated. The duty to report changes shall, in particular, apply to changes in the policyholder's name, address, mailing address, and the composition of the insured group, its work activity, occupational hazards, and the number of insured persons in the group.

III.2.8. If there is change in an insured group defined by the names of group members, or in an insured group defined by the names of group members and subject to medical underwriting, the policyholder is required to disclose the data specified in Clause III.2.5. for the **new insured** and/or for the **departing insured** (insured persons) to the insurance company within 5 workdays following such change.

III.2.9. If the number of insureds in an insured group defined by the number of group members changes by more than 10% – relative to the number last communicated to the insurance company in writing – the policyholder is required to file a written report to the insurance company within 5 workdays with the following data:

a) the number and name of the insured group,
b) the date of the change that exceeds 10%,
c) the modified number of insured persons as at the time of the modification.

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 material circumstances regarding the policy, the insurance coverage of an insured or a change thereof only after the policy has been concluded,** and these circumstances bring about a considerab le increase in the insured risk, the insurance company shall be entitled to complete underwriting with respect to the particular insured person(s), and as a result the insurance company may propose within fifteen days after gaining knowledge thereof that the policy be amended or may cancel the coverage – with respect to the particular insured – in writing with thirty days' notice.

A **considerable increase in the insurance risk** shall, in particular, include cases when had the insurance company known about the material circumstance, it would have applied a premium adjustment, surplus premium or exclusion, 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 notifies the insurance company within 15 days of receipt of the proposed amendment that he **does not accept** the proposed amendment, the policy or the provisions applicable to the particular insured **will terminate** on the 30th day after the notification of the amendment was served.

If the policyholder **fails to respond** to the proposal for amendment within fifteen (15) days from the time of receipt thereof, **the policy shall be amended** in accordance with the proposal on the thirtieth (30th) day following the day of communicating the proposal for the amendment, provided that the insurance company warned the policyholder of this consequence when the proposal for amendment was made.

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

III.3.1. and in Clause III.3.2. with respect to the other insured persons.

IV. INSURANCE PREMIUM

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

IV.1.1. The insurance premium is received in consideration of the insurance coverage provided by the insurance company.

IV.1.2. The entry age of the insured:

a) with respect to life and accident insurance coverage, the entry age of the insured may be 16 – 74 years of age,
b) with respect to health insurance coverage, the entry age of the insured may be 16–64 years of age in the cases set out in the Premium Rates Regulation – depending on the number of the insured persons – or 16–74 years of age in other cases.

IV.1.3. The insurance company shall determine the entry age of the insured by deducting the insured's year of birth from the calendar year in which the insurance coverage with respect to the particular insured takes effect.

IV.2. Calculation of the Insurance Premium

IV.2.1. The insurance premium shall be calculated with respect to the number of the insured persons, their occupation, the type of the insurance coverage (24-hour or workplace accident and workplace road accident insurance), the medical conditions of the insured and the sum(s) insured. In addition to the above, the insurance company shall take into account the insured persons' entry age in the cases set forth in the Premium Rates Regulation.

The insurance premium shall be determined once again if the policyholder notifies the insurance company that the number of the insured persons has changed.

IV.2.2. If the insured's year of birth was misstated, and as a consequence the premium determined was lower than necessary, the benefit payout shall be in line with the actual entry age of the insured and the premium actually paid if an insured event occurs.

If the calculated premium exceeds the required amount, the insurance company shall refund the premium surplus to the policyholder.

IV.2.3. Where it is established that the insurance coverage could not have been offered on the basis of the actual year of birth (Clause IV.1.2), the insurance company will follow the procedure set out in Clause III.3.1, or it may challenge the particular coverage of policy.

IV.3. Insurance Premium per Insured

IV.3.1. The insurance company shall determine the insurance premium per insured for each insured group separately.

Within any one insured group, the insurance premium per insured shall be identical.

IV.3.2. If the number of the insured persons change, or when medical underwriting is required for the insured persons, the insurance company will modify the insurance premium set out for the insured group taking into account the amount of the premium defined in Clause IV.3.1., with effect from the first day of the month following the month in which the change in the number of insured persons has been reported, or when the insurance coverage is approved by the insurance company.

IV.4. Payment of the Insurance Premium

IV.4.1. The **annual premium** applicable to the policy year may be settled in monthly, quarterly, or semi-annual installments.

IV.4.2. The policyholder will specify the premium payment frequency when completing the insurance application, which may be modified with effect from any insurance renewal date if the intention to make a modification is communicated to the insurance company in a written notice at least 60 days before the policy's renewal date.

IV.4.3. The first premium of the insurance shall be due at the time when the policy is concluded, and any later premium shall be due on the first day of the period (year, half-year, quarter, month) which it is payable for.

IV.4.4. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the insurance premium (premium installment) is received by the tied insurance intermediary (agent) against receipt or in other cases when it is credited on the insurance company's account.

IV.4.5. The policyholder agrees to pay the insurance premium applicable for all the insured persons - in accordance with the due dates of the premium (premium installment) - in one sum.

IV.5. Consequences of Premium Payment Default

IV.5.1. If the policyholder fails to settle the insurance premium by the due date, the insurance company will send the policyholder a written payment reminder with at least an additional thirty-day deadline including advice on the legal consequences of payment default.

IV.5.2. 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.5.3. 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.6. Reactivation

IV.6.1. Reactivation is the reinstatement of the insurance coverage of a policy which was terminated due to a premium payment default, on the original policy terms.

IV.6.2. If an insurance policy is terminated due to a premium payment default, the policyholder may request the reactivation of the insurance coverage in writing within 120 days after the termination date of the policy (Clause IV.5.2.). In such a case, the insurance company shall be entitled to carry out an underwriting procedure and to approve the request or deny it without giving reasons.

IV.6.3. The terminated coverage will be reactivated with identical content and sums insured if the insurance company approves the reactivation request, and sends written notification to the policyholder of such fact, and the policyholder pays all the unpaid and due premiums within 8 days following the approval of the reactivation request.

In such a case the insurance coverage is reinstated as at 0 hours of the day following the day when the unpaid and due premiums (premium installments) are settled, with retroactive effect to the date when the policy was terminated.

As a result of the reactivation, the insurance coverage shall be continuous.

IV.6.4. Reactivation may be requested no more than twice within the policy period.

IV.7. Annual Indexation, an Option to Preserve the Value of the Insurance

IV.7.1. In order to preserve the value of the insurance, the insurance company offers a possibility to increase the insurance premium as well as the sums insured on an annual basis (hereinafter: annual indexation). Annual indexation may be applied as of the insurance anniversary of the policy.

IV.7.2. To determine the rate of the annual indexation the insurance company shall use the product of the monthly consumer price indexes of 12 months preceding the fourth month before the insurance anniversary of the policy, expressed in a percentage (hereinafter: 12-month price index) disclosed in the Consumer Price Index publication of the Hungarian Central Statistical Office.

If the 12-month price index is below 5%, the insurance company shall apply a 5% annual indexation base rate.

IV.7.3. If the policyholder submitted a request for annual indexation and the insurance company approved the request, 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 60 days before the renewal date, within the framework of the annual indexation procedure. The policyholder is entitled to refuse the annual indexation within 30 days upon receipt of notification thereof. **If the policyholder does not expressly refuse the annual indexation within the 30-day time limit, the insurance policy shall continue to be in force with the increased sum insured and insurance premium from the insurance anniversary.**

IV.7.4. 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 written notice set out in Clause IV.7.3.

IV.7.5. If the policyholder did not request annual indexation at the time of completing the insurance application form, or if the policyholder specifically refused it on any insurance renewal date, the insurance company is entitled to carry out underwriting for any subsequent indexation, and conditionally, approve or deny the request without giving reasons.

IV.7.6. If the parties agree to an insurance anniversary different from the one set out in Clause II.3.4 and there are less than 180 days between the effective date of the insurance coverage and the insurance anniversary, the insurance company shall not offer annual indexation on this first insurance anniversary.

IV.8. Adjustment of the Insurance Premium

During the policy period, the insurance company may propose that the insurance premium be modified.

The insurance company will communicate its proposal for the modification of the insurance premium to the policyholder in writing and at least 30 days prior to the next renewal date of the policy.

If the policyholder does not wish to maintain the insurance with the proposed modifications communicated by the insurance company, the policyholder may cancel the insurance policy without a notice period – prior to the insurance anniversary – with effect from the insurance anniversary.

The insurance premium will be modified in accordance with the insurance company's proposal – with effect from the next insurance anniversary – if the policyholder does not exercise his right to cancel the policy or if the policyholder approves the proposed modification by paying the modified premium due after the insurance anniversary.

V. INSURED EVENTS, INSURANCE BENEFITS AND COVERED SERVICES, PAYMENT OF CLAIMS

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, Covered Services

If an event that is defined as an insured event in the Special Conditions occurs, the insurance company shall pay the insurance benefit specified in the Special Conditions. The insurance company will only reimburse costs which are specifically stated in the policy conditions. The costs incurred in connection with the submission of a notice of claim are only reimbursed by the insurance company if the insurance company expressly undertakes this obligation in the Special Conditions.

V.3. Payment of Claims – Payment Conditions

V.3.1. Method of and Deadline for Notifying an Insured Event

An insured event is required to be notified in writing to the insurance company **within 15 days of its occurrence.**

Where the **above time limit is not respected,** and 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 **material conditions or circumstances cannot be revealed, the insurance company may be released from its obligation to pay the claim.**

V.3.2. Documents Required for the Settlement (Payment) of Claims

When a **notice of claim for life insurance proceeds or accident and health insurance benefits is submitted,** the following documents **shall also be attached in addition to those set out in the Special Conditions:**

a) proof of employment (II.1.3.) with respect to the given insured (employer's certificate),
b) a written accident & injury report drawn up by the policyholder, which shall contain the place and the exact time of the accident, the personal particulars of the person who is injured in the accident, the detailed circumstances and the consequences of the accident, as well as the personal particulars and contact details of the witnesses if the accident happened at work, during performing work duties,
c) if necessary, the verification of the fact that the particular insured is covered under the insurance policy.

V.3.3. Other Documents to be Requested for Claim Settlement

In addition to the documents specified in these General Conditions and the Special Conditions, the **insurance company is entitled to require that a copy of the following documents** verifying the existence of the legal ground for the claim and/or necessary for determining the amount of the insurance benefit payable **shall also be submitted** for the assessment of the insurance claim:

V.3.3.1. If an official investigation was initiated in connection with the insured event or the circumstances leading to such event, all the documents produced or used in the proceedings, as well as the resolution closing the proceedings (in particular the resolution terminating the proceedings, or a binding court decision). A binding court decision made in criminal proceedings, or a binding resolution adopted in misdemeanor proceedings only if this is available when the notice of claim is submitted;

V.3.3.2. **Documents suitable for the clarification of all the circumstances and consequences of the insured event** (a statement made by the insured and/or any other person involved in the insured event about the circumstances of the insured event, the accident & injury report issued by the police, the employer, the school, or the passenger carrier company, resolutions, experts opinions in connection with the accident/consequences);

V.3.3.3. 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.3.3.4. 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 administration of pharmaceuticals;

V.3.3.5. **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.3.3.6. 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.3.3.7. An official certificate in proof of the insured's date of birth (birth certificate, identification card, passport, driver's license);

V.3.3.8. The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out;

V.3.3.9. 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 the decision making;

V.3.3.10. 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;

V.3.3.11. The insurance company may obtain further documents for the settlement of the insurance claim.

V.3.4. Deadline for Payment of Claim

V.3.4.1. The insurance company will settle the insurance claim **within 15 (fifteen) days upon receipt of the notice of claim as well as all other documents necessary for claim settlement, provided that – in respect of death claims – the due diligence of the policyholder has been completed if it is required pursuant to Act CXXXVI of 2007 on the Prevention and Combating of Money Laundering and Terrorist Financing.**

V.3.4.2. If the documents required by the insurance company are not submitted or are incomplete despite a reminder, the insurance company will assess and settle the claim on the basis of the documents available.

V.3.4.3. If the available documents do not prove to be sufficient for the settlement of the insurance claim, the insurance company may require that the insured should attend a medical examination. If the insured fails to attend the medical examination, the insurance company will be entitled to make a decision on the basis of the evidence available.

V.3.4.4. 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.

VI. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT

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 duty to communicate the required information or to notify changes, the insurance company's obligation to pay the claims 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 coverage period 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 unreported circumstance did not contribute to the occurrence of the insured event.**

VI.2. Exemption of the Insurance Company from the Payment of Life Insurance Claims

VI.2.1. The insurance company will be released from its obligation to pay the claim in the cases listed under Clause VI.1.

VI.2.2. The insurance company will be released from its obligation to pay the claim if

a) the insured dies as a result of suicide within two years of the commencement of the coverage applicable to the particular insured, 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 of the beneficiary, in which case the insurance benefit shall be fully paid to the heirs of the insured, and the beneficiary shall not be provided any part of that.

VI.3. Exemption of the Insurance Company from Accident Insurance Claims Payment

VI.3.1. The insurance company will be released from its obligation to pay the claim in the cases listed under Clause VI.1.

VI.3.2. The insurance company will be released from its obligation to pay the claim if the insured dies as a result of the beneficiary's willful misconduct. In that case, the insurance benefit shall be fully paid to the heirs of the insured, and the beneficiary shall not be provided any part of that.

VI.3.3. The insurance company will be released from its obligation to pay the claim if the insurance company can prove that the loss or damage was caused unlawfully and willfully or unlawfully and in gross negligence by the insured.

The insured shall be acting in gross negligence in particular if:

a) the insured was demonstrably under the influence of alcohol, drugs or other stupefying agents at the time of the insured event, and this fact contributed to the occurrence of the insured event. If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,
b) the insured operated a motor vehicle without a valid vehicle registration certificate or the insured did not have a valid license required for driving such vehicle, and this fact intervened in the occurrence of the insured event,
c) the insured has committed at least two traffic offenses at the time of the insured event, and as such the insured event resulted directly from these actions.

VI.3.4. 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 of medical treatment – due to statutory patient autonomy and freedom to decide – shall not be a breach of their duty to mitigate loss. If the insured fails to comply with this obligation, the insurance company will be released from its obligation to pay the claim.

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) HIV infection
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, terrorism, work misbehavior, border conflicts, insurrection.

VII.1.2. For the purposes of these General Conditions, terrorism shall in particular mean unlawful acts involving he use of violence or threat of violence especially against human life, tangible or intangible assets or the infrastructure, in the pursuit of political aims, religious, ideological, or ethnic change or 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), the insurance covers any physical or mental impairment of 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. If the insurance policy is concluded without medical underwriting (medical history statement, medical tests, health check), then within 5 years after the commencement of the insurance coverage applicable to the particular insured person, the insurance does not cover events which are the direct results of the following cases:

a) such illness or pathological condition of the insured that has been proven to have existed during any time in the 1 (one) year prior to the inception of the insurance coverage applicable to the particular insured, or any illness that had been diagnosed during any time in the 1 (one) year prior to the inception of the insurance coverage applicable to the particular insured, or any illness that required treatment or medical control during this time period,
b) the insured's permanent disability established prior to the commencement of the insured's insurance coverage.

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

The insurance does not cover the events which take place during the coverage period, if

a) the event was the result of the insured's regular alcohol consumption, recreational drug use, or there was a direct connection between the event and the abuse of narcotic substances or medical drugs, unless these latter were prescribed by a physician, and were taken in the recommended manner,
b) the insured was verifiably intoxicated or under the influence of drugs, stupefying agents or medication at the time of the event, and this fact contributed to the occurrence of the event. If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,
c) the insured operated a motor vehicle without a valid driver's license or vehicle registration certificate as well at the same time also committed other traffic violations, and the event resulted directly from these actions,
d) the insured operated a motor vehicle while legally intoxicated when the insured event occurred and at the same time also committed other traffic violations, and the event resulted directly from these actions.

VII.3. Exclusions Applicable to Accident and Health Insurance Covers

VII.3.1. 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 applicable to the particular insured. The insurance company understands conception to have taken place prior to the commencement of coverage if the number of days between the commencement of the insurance coverage applicable to the insured and the expected delivery date recorded in the official supporting documentation (ex: Medical record of pregnancy booklet) is less than 285 days.

VII.3.2. The insurance does not cover the abortion of a pregnancy, unless the abortion was necessary to preserve the life or health of the mother, or if the abortion was performed in a case where the pregnancy was the result of a criminal act.

VII.3.3. 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) sterilization,**
- **d) sex reassignment,**
- **e) treatment for aesthetic purposes, cosmetic surgery and its consequences,**
- **f) dental implants.**

VII.3.4. In the event that the insured requires life saving intervention as a result of any of the events listed in Clauses VII.3.1, VII.3.2, and VII.3.3, the insurance will cover the events which are the result of the conditions requiring medical care.

VII.3.5. The insurance does not cover events caused in whole or in part by:
- **a) hospital care which is NOT aimed at diagnosing the insured's illness, or preventing the further deterioration of the insured's condition, or restoring the insured's health, including but not limited to screening tests, or a parent staying at the hospital with his/her child, or the insured's stay at the 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, step-parent'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 aimed at diagnosing a chronic illness, initiating a therapy, or preventing a significant deterioration of acute conditions,**
- **d) treatment performed by a person who does not have medical certification and a license to practice medicine.**

VII.3.6. The insurance does not cover psychological conditions, mental and psychiatric disorders.

VII.3.7. The insurance does not cover health insurance events which arise from the insured's suicide or suicide attempt, not even in the event that the insured was mentally incompetent at the time of the incident.

VII.4. Exclusion of sport injuries

The insurance does not cover events which are in a causal relation to the insured's sports activities classified to be of extreme risk, as listed in Schedule B of these General Conditions.

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 certificate of coverage with the same content as that of the effective one. Any costs incurred in this relation, shall be borne by the policyholder.

VIII.3. Procedure to Settle Disputes or Disagreement

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 customer.

IX. TERMS AND DEFINITIONS

IX.1. Accident, workplace accident, workplace road accident, and road traffic accident

IX.1.1. For the purposes of these General Conditions, **accident** means a sudden, one-time, external physical and/or chemical impact that the insured is exposed to beyond his/her control during the coverage period, and as a result of which the insured suffers injuries or dies.

IX.1.2. For the purposes of these General Conditions, **accident also means:**

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 poliomyelitis or meningitis and/or encephalitis,

b) rabies, if the illness has been diagnosed, and has appeared the earliest a minimum of 60 days after the effective date of the insurance coverage, or the latest a maximum of 60 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 rabies.

c) tetanus infection, if the illness has been diagnosed, and has appeared the earliest a minimum of 20 days after the effective date of the insurance coverage, or the latest a maximum of 20 days after termination of the insurance contract. The onset of the illness is the day when the insured has first 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 mean:**

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.1.4. For the purposes of these General Conditions, **workplace accident** means any accident that the insured suffers while performing his/her work duties and activities, or in relation thereto.

Workplace accident shall not mean accidents arising from or in relation to work executed without an approval.

IX.1.5. For the purposes of these General Conditions, **workplace road accident** means an accident that the insured suffers while travelling from his/her home (accommodation) to work, or from work to his/her home (accommodation) taking the shortest possible route.

IX.1.6. For the purposes of these General Conditions, **road traffic accident** means an accident suffered by the insured provided that the insured was involved in the accident as a pedestrian, or the driver of or a passenger in a vehicle.

IX.1.7. For the purposes of these General Conditions, **road traffic accident** does not mean:

a) pedestrian accidents in which no other moving road users or vehicles were involved,

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.2. Illness, hospital, surgery and list of surgeries

IX.2.1. For the purposes of these General Conditions, **illness** is any deviation from or interruption of the normal structure or function of the human body.

IX.2.2. For the purposes of these General Conditions, **hospital** means institutions which provide in-patient care and operate under permanent medical attendance and control recognized and licensed by the Hungarian Medical Officer Service and Professional Supervision.

IX.2.3. For the purposes of this insurance, **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 institutes, 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.2.4. For the purposes of the these General Conditions, **surgery** means the medical procedures classified by the insurance company which involve an incision of the integument and/or the mucous tissue for the purposes of preserving health, treating illnesses, and mitigating the medical consequences of the above, performed in compliance with the standard rules of medical practice.

IX.2.5. On the basis of their severity, the insurance company classifies surgeries into categories (hereinafter: classification of surgeries).

IX.2.6. For the purposes of these General Conditions, the **list of surgeries shall be a list of medical procedures identified by codes used in the international classification of procedures in medicine (WHO codes). The list of surgeries shall also indicate the classification established and applied by the insurance company.**

The list of surgeries is available in the insurance company's Home Office or at its Personal Insurance Competence Centers.

IX.2.7. For the purposes of these General Conditions, the abstracted list of surgeries is a short version of the complete list of surgeries (refer to Schedule D, which shall form an integral part of the General Conditions). The abstracted list contains the most common, most frequent surgeries with their corresponding WHO codes and the classification defined by the insurance company.

The purpose of the abstracted list of surgeries is to illustrate the concept of how the insurance benefit is determined. Unless otherwise agreed and stipulated by the parties, the abstracted list of surgeries shall form an integral part of the insurance policies concluded subject to these General Conditions.

IX.2.8. If a surgery is performed, the insured event and in turn, the classification of all medical procedures performed shall be determined on the basis of the list of surgeries by the physician designated by the insurance company. A basic document to assist with the classification is the list of surgeries.

IX.2.9. If a surgical procedure performed is not included in the list of surgeries, its classification will be decided by the insurance company's physician.

X. STANDARD PROVISIONS OF THE GENERAL CONDITIONS WHICH SUBSTANTIALLY DEROGATE FROM THE PROVISIONS OF THE HUNGARIAN CIVIL CODE

This chapter summarizes the provisions of the General Terms and Conditions of Employer's Group Insurance which substantially differ from the respective provisions of the Hungarian Civil Code.

X.1. Standard Terms of these General Conditions that Substantially Derogate from the Provisions of the Hungarian Civil Code

X.1.1. Consent required on behalf of the insured party

Pursuant to Clause II.1.5. of these conditions, and by way of derogation from Section 6:479. (1) of the Civil Code, the policy may be validly concluded **without the consent of the guardian authority** if the insured is a minor, or a person 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.

X.1.2. Conclusion, modifications and termination of the insurance policy

Pursuant to Clause II.1.6. of these conditions, and by way of derogation from Section 6:478 (2) of the Civil Code, unless otherwise agreed by the parties, **the policyholder waives his right to designate a beneficiary to the insured person,** and informs the insured of this fact.

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.2.12. of these 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.**

Pursuant to Clause II.2.13 of these conditions, and by way of derogation from Section 6:475 of the Civil Code, **the consent of the insured is not required for amending the insurance policy.**

Pursuant to Clause II.2.15 of these conditions, and by way of derogation from Section 6:444. (1) of the Civil Code, even if the **policyholder is not a consumer,** the policy shall be executed – 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.

Pursuant to Clause II.3.5. of these conditions, and by way of derogation from Section 6:480. of the Civil Code, the insurance company may set out a waiting period of no longer than six (6) months (hereinafter: waiting period), **the first day of which shall be the commencement of the coverage pertaining to the insured.**

Pursuant to Clause II.5.2. of these conditions, and by way of derogation from Section 6:483. and Section 6:490. of the Civil Code, the insurance company is entitled to **terminate the insurance policy for convenience.**

Pursuant to Clause III.3.2 of these conditions, by way of derogation from Section 6: 446 (2) of the Civil Code, if the policyholder **fails to respond to the proposal for amendment** within fifteen (15) days from the time of receipt thereof, **the policy shall be amended in accordance with the proposal on the thirtieth (30th) day following the day of communicating the proposal for the amendment,** provided that the insurance company warned the policyholder of this consequence when the proposal for amendment was made.

X.1.3. Additional Payment Deadline

Pursuant to Clause IV.5.1. of these 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-day deadline if the policyholder fails to settle the insurance premium by the due date.

X.1.4. Obligation to disclose information and notify changes

Pursuant to Clause VI.1.1 of these conditions, and by way of derogation from Section 6:482 (1) of the Civil Code, the insurance company shall be entitled to exercise the rights arising from the breach of the obligation to disclose information and report changes **without restrictions.**

X.1.5. 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.**

Effective from: September 1, 2017

Schedule A
Hazardous Occupations

1. **Workers of aviation services other than civil aviation:** workshop pilots, advertising airplane pilots, pest control aircraft pilots, aircraft photographers, helicopter rescue, helicopter police, construction by helicopter, helicopter transportation, helicopter pest control.
2. **Army flight crew:** piston engine aircraft crew in the army, army cargo aircraft crew, helicopter crew, flight instructors, student pilots, test pilots, parachute jumpers, jet plane crew in the army.
3. **Mine workers:** mining operators, mining technicians, sink miners, mine supervisors, mine operators, loader operators, splitters, cutters and carvers, oil miners, cement, stone and other mineral products machine operators.
4. **Metal processing and finishing plant workers:** metal processing and finishing plant operators, metal processing technicians, metal processing plant workers, coating machine operators, ferrous and non-ferrous smelters, tinsmiths
5. **Workers dealing with explosives and highly flammable substances:** shotfirers and blasters, pyrotechnists,
6. **High voltage engineering workers:** high voltage engineering technician, skilled and trained workers.
7. **Industrial alpinists**
8. **Industrial divers**
9. **Occupations in the armed forces:** bodyguards, commando staff, foreign legionnaires, secret agents, armed guards, armed guards in prison services, prison supervisor, prison guards, security guards, security guards with a self-defence weapon, armored car personnel, contractors working in the army or persons in conscription (who pursue increased danger activities: bomb experts, divers)
10. **Peacekeepers**
11. **Radioactive decontamination apparatus operator**
12. **Stuntman**

Effective from: September 1, 2017

Schedule B
Classification of Sports Risks

Sports may be categorized by how dangerous they are:
Sports of average, medium, high, excessive and extreme levels of risks.

Average level of risk: table football (foosball); billiard; bridge; snorkelling; callanetics; curling; spear throw; rowing; javelin throw; golf; archery; kayak-canoe; modelling; synchronized swimming; paintball; radio sport; chess; shooting sport; arm-wrestling; tai chi; kegel; hiking; swimming; hunting.

Medium level of risk: table tennis, scuba diving under 40m; powerlifting; foot-bag; jet-ski; kitesurfing; cricket; equestrianism (horseback riding); springboard diving; pentathlon; weightlifting; surfing; body-building; platform diving; sailing; fencing; waterpolo; water-skiing; wakeboard; wakekite.

High level of risk: aerobics; aikido, acrobatic Rock & Roll, baseball; squash; fitness; running; speedwalking; speed-skating; rope-jumping; football tennis; shuttlecock; ice dancing; rhythmic gymnastics; skiing; orienteering; tennis; badminton; competitive dancing.

Excessive level of risk: American football; track and field; heptathlon, decathlon; wrestling; bmx; bmx-cross; bob; dirt jumping; floorball; futsal; skate-boarding; roller-blading; field hockey; speed biking; hapkido; martial arts; iaido; ice-hockey; judo; kapoeira; karate; kempo; kendo; handball; kick-boxing; kitebuggy; korfball; basketball; kung-fu; soccer; mountainbike; mountainboard; figure skating; road biking; professional wrestling; rugby; aerial skiing; downhill, slalom, giant slalom; ski jumping; skate; snowboard; luge/skeleton; sumo; taekwando; thai-boxing; gymnastics.

Extreme level of risk: auto-crash sport; caving, cave expeditions; BASE jumping; scuba diving under 40m; canyoning; parachute jumping; go-kart sport; mountaineering; rock-climbing from peg 5.; hot-air ballooning; hydrospeed; ballooning; high-mountain expeditions; bungee jumping; moto-cross; motorboat sports; motorcycle sports; stunt flying; paragliding; quad; rally; hanggliding and ultra-light flying; paragliding; sports flying; sports flying parachute jumping; ability competitions by car; whitewater rafting; racing: by car; sailing: one-arm and open sea sailing; motor sail plane.

Effective from: September 1, 2017

Schedule C
Permanent Disability Ratings

Table referred to in the Special Conditions of Permanent Partial Disability Insurance (Accidents only) and in the Special Conditions of Permanent Partial Disability Insurance (Road Accidents) 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	% degree of permanent impairment
amputation of an arm at shoulder joint, or its permanent loss of function	70%
amputation of an arm above elbow joint, or its permanent loss of function	65%
amputation of an arm below elbow joint, or amputation of a hand, or its permanent loss of function	60%
amputation of a thumb or its permanent loss of function	20%
amputation of an index finger or its permanent loss of function	10%
amputation of any other finger or its permanent loss of function	5%
amputation of a leg through the hip joint or the permanent loss of function of the hip joint	70%
partial amputation of one leg above knee joint or the permanent loss of function of the knee joint	60%
partial amputation of a leg below knee joint	50%
ankle disarticulation or the permanent loss of function of the ankle joint	30%
amputation of a great toe or its permanent loss of function	5%
amputation of any other toe or its permanent loss of function	2%
total vision loss in both eyes	100%
total vision loss in one eye	35%
total vision loss in one eye, if the insured has already lost vision in the other eye prior to the occurrence of the insured event	65%
total hearing loss in both ears	60%
total hearing loss in one ear	15%
total hearing loss in one ear, if the insured has already lost hearing in the other ear prior to the occurrence of the insured event	45%
complete loss of smell	10%
complete loss of tasting	5%

Effective from: September 1, 2017

Schedule D
Abstracted List of Surgeries

Abridged List of Surgical Procedures applicable to the Special Conditions of Accident Insurance with Surgery Benefit and Surgery Benefit Insurance.

If an insured event occurs, the insurance company shall pay out the following insurance benefits under any Surgery Insurance (Accidents) and Surgery Insurance:
for surgeries in Category 1, 100% of the sum insured,
for surgeries in Category 2, 50% of the sum insured,
for surgeries in Category 3, 25% of the sum insured,
for surgeries in Category 4, 15% of the sum insured.
surgeries in Category 5 are not covered.

If the insured has a surgery which belongs to Category 5, no benefit may be claimed.

An abstracted list of surgeries by categories:

Category 1

WHO code	Surgery
5014F	Resection of intracranial tumor
50151	Resection of skull tumor
50200	Elevation of depressed skull fracture
50303	Surgical spinal decompression
50311	Surgery of the spinal nerve root in the spinal canal
50337	Recession of spinal tumor
53240	Lung lobectomy
53340	Pulmonary transplantation
53522	Replacement of mitral valve with mechanical articificial valve
53531	Plastic repair of mitral valve
53734	Resection of ventricular tumor
53743	Ventricular repair, cardiorrhaphy
53750	Cardiac transplantation
55040	Hepatic transplantation
58151	Total hip replacement
5814L	Total knee arthoplasty

Category 2

WHO code	Surgery
54560	Total colonectomy
53611	Coronary artery bypass graft surgery
53502	Closed incision on the mitral valve
5382L	Removal of abdominal aortic aneurysm
53836	Blood vessel replacement
51358	Iridectomy
51570	Vitrectomy
53163	Neoglottis formation

Category 3

WHO code	Surgery
53777	Pacemaker implantation
53807	Femoral embolectomy
54130	Splenectomy
54361	Partial gastrectomy
54700	Appendicectomy
55110	Cholecystectomy
55300	Surgical correction of inguinal hernia
56011	Transurethral reduction of prostate
56520	Unilateral ophorectomy
56830	Abdominal hysterectomy
50630	Thyroidectomy
51150	Conjuctiva suture
57902	Pinning the femoral neck
57922	Stretching loop fixing of the bone
57924	Screwing

Category 4

WHO code	Surgery
51440	Crystalline lens removal
51470	Lens transplantation
51950	Tympanoplasty
53844	Removal of varicose veins
56741	Cervix surgery
56518	Laparoscopic ophorectomy
57400	Ceasarian section
57670	Open restoration of facial fractures
57829	Bunion surgery
57900	Closed reduction of fracture with internal fixation
58130	Suture of the ligament on the outer ankle
5837H	Restoration of torn Achilles' tendon
58600	Lumpectomy

Category 5

WHO code	Surgery
14410	Biopsy taken during gastroscopy for histopathology testing
14820	Percutaneous biopsy from breast for histopathology testing
16200	Bronchoscopy
16970	Diagnostic reflection of joint
33121	Coronary angiographia
39430	Extracorporeal shock wave lithotripsy for kidney stones
52160	Reconstruction of nose fracture
52310	Surgical removal of a tooth
52374	Dental osteoplasty
52000	Myringotomy
52100	Control of epistaxis by hardening substance
52810	Tonsillectomy
57100	Episiotomy
57520	Termination of pregnancy (abortion)
57880	Removal of internal steel pins (wires or pins)
58750	Plastic surgery of breast
58900	Skin suture
58840	Surgical removal of achrochordon
59801	Female surgical sterilization
81010	Removal of foreign body from cornea
81700	Lacrimal sac washout
82032	Closed reduction of fracture of wrist
58830	Wound cleaning, debridement
82090	Closed fixing of luxation
84712	Stretching with wiring drilled into femur
85840	Injection administered into a joint
88050	Blood transfusion
88530	Dialysis

Effective from: September 1, 2017

Special Conditions of Accidental Death Insurance (KBHAT/02017)

These Special Conditions set out the standard terms and conditions for the **accidental death cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the policy period, **as a result of which the insured dies within one year after such accident.**

I.2. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. In the event that an insured event specified in the policy occurs, that is the **insured suffers an accident during the coverage period and as a result dies within one year** – and the insurance claim is grounded – **the insurance company pays the sum insured specified in the certificate of coverage in force at the time when the insured dies to the death beneficiary.**

II.2. If the **insured dies after the termination of this insurance policy as a result of an accident** which occurred while the insurance policy was in force, but the insured's death is within one year after the date of the accident specified as the insured event, the insurance benefit payout will be determined on the basis of the **sum insured specified in the most current effective certificate of coverage.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) cause of death medical certificate / hospital course summary,
b) the autopsy report,
c) the insured's certificate of death,
d) all medical documents produced in connection with the insured event from the occurrence of the accident until a notice of claim is submitted, in particular the medical documentation of the first medical treatment,
e) the accident & injury / police report, if available,
f) the result of the blood alcohol and/or drug test, if available,
g) in the case of a road traffic accident, in addition to the above: if the insured **was injured or died** in a road traffic accident **as the driver of a motor vehicle,** the driver's license and the vehicle registration certificate,
h) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy,

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a death claim arising from an accident in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Permanent Disability Insurance with Linear Benefit Payment (Accidents only) (KBROK/02017)

These Special Conditions set out the standard terms and conditions for the **permanent disability insurance cover with linear benefit payment (accidents) available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the coverage period and **as a result of which the insured suffers permanent impairment.**

I.2. **Disability** means a **loss or impairment of a physical and/or mental function which impedes the ordinary pursuits of life.**

I.3. **Disability shall be permanent** if the impairment of the insured is medically **fixed, lasting and stable.** If the degree of the impairment is **continuously changing,** but 2 years have passed since the date of the accident, then after the expiry of the 2 years, the **medical expert of the insurance company shall be entitled to determine the degree of confirmed permanent disability,** which the insurance company shall regard as **permanent disability arising from an accident** for the purposes of the insurance company's payment of insurance benefits and with respect to the amount of such benefits. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. No adverse aesthetic effect or other **(social, financial, etc.) detriment** arising from or in relation to the accident **shall in itself be grounds for an insurance claim** with respect to permanent disability.

I.4. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. **The insurance benefit is paid out only if the disability is** confirmed to be **permanent** (Clause I.3. of these Special Conditions).

II.2. **If an insured event occurs, the benefit payout** by the insurance company shall be the **percentage of the sum insured stated in the certificate of coverage** effective at the time when the permanent impairment is determined, or in the absence thereof the sum insured stated in the certificate of coverage effective at the time when the insurance policy was terminated, **corresponding to the degree of the permanent partial disability,** also taking into account Clause II.9. of these Special Conditions.

II.3. The **extent (degree) of any permanent disability** on which the insurance claim is based, **shall be confirmed by the insurance company's medical examiner pursuant to the table in Schedule C which shall form an integral part of the General Conditions.**

II.4. If the extent of the disability **cannot be established on the basis of the table,** the insurance benefit shall be determined by a **medical review of any loss or abnormality of physiological, psychological, or anatomical structure or function.**

Organs or body parts injured permanently before the date of the accident shall be excluded from the insurance coverage up to the extent of the former injury.

The extent of permanent impairment determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (permanent impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the permanent impairment by the insurance company's medical examiner, or for specifying the permanent disability benefit amount payable by the insurance company.

Furthermore, the advice or resolution of any other medical board shall not be binding on the insurance company when determining the permanent state of the disability or the degree of permanent partial disability.

II.5. The **extent** of the **permanent disability** resulting from any one insured event **may not be higher than 100%.**

II.6. **If the insured dies before his/her impairment is stabilized, the benefit shall be determined on the basis of the extent of the impairment confirmed by the insurance company's medical examiner on the basis of the documents of the last medical examination.**

II.7. **No benefit may be claimed** on permanent health impairment **if the insured dies within 15 days after the accident.**

II.8. If the **insurance company has already established that the claim for an insurance benefit is grounded** but the benefit amount cannot be determined yet, the **insured may require** that the insurance company would pay the **minimum benefit amount** due under the given coverage.

II.9. **If the insurance company has already made an insurance benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file supplementary insurance claims,** supported by all the necessary medical documents in proof of the deterioration of the insured's condition despite appropriate medical treatment, once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim, and may request that his/her condition be reassessed and the degree of the permanent disability be determined again. Based on the findings of the medical review, the insurance company shall pay the insurance benefit in accordance with Clause II.2 of these Special Conditions, on the understanding that **benefit payouts made earlier on the insured event specified above shall be deducted from any later benefit payout.**

Even in such a case, the extent of the permanent disability resulting from the same insured event **may not be higher than 100%.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, **the insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment.
b) the accident & injury report, if available,
c) the result of the blood alcohol and/or drug test, if available,
d) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate,
e) other documents required for the full clarification of the circumstances of the accident.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions** – for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.7. **If the insurance claim is grounded, the insurance company will settle the insurance claim within the following deadlines:**

a) if the claim is for a **permanent disability benefit and the permanent impairment has been medically confirmed,** the insurance company shall make the payout **within 15 days upon receipt of the last document** required for the assessment of the insurance claim,
b) **in other cases,** the insurance company shall make the payout **within 15 days after the impairment is confirmed to be permanent, or within 15 days after the expiry of 4 years following the accident.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for the permanent disability benefit (accidents) in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Permanent Disability Insurance with Progressive Benefit Payment (Accidents only) (KBROK/12014)

These Special Conditions set out the standard terms and conditions for the **permanent disability insurance cover with progressive benefit payment (accidents) available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the coverage period and as a result of which the insured suffers permanent impairment.

I.2. **Disability** means a **loss or impairment of a physical and/or mental function which impedes the ordinary pursuits of life.**

I.3. **Disability shall be permanent** if the impairment of the insured is medically **fixed, lasting and stable.** If the degree of the impairment **is continuously changing,** but 2 years have passed since the date of the accident, then after the expiry of the 2 years, the **medical expert of the insurance company shall be entitled to determine the degree of confirmed permanent disability,** which the insurance company shall regard as **permanent disability arising from an accident** for the purposes of the insurance company's payment of insurance benefits and with respect to the amount of such benefits. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. No adverse aesthetic effect or other **(social, financial, etc.) detriment** arising from or in relation to the accident **shall in itself be grounds for an insurance claim** with respect to permanent disability.

I.4. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. **The insurance benefit is paid out only if the disability is** confirmed to be **permanent** (Clause I.3. of these Special Conditions).

II.2. **If an insured event occurs, the benefit payout of the insurance company will be the percentage of the sum insured stated in the certificate of coverage** that is in force at the time when the permanent impairment is established, or in the absence thereof in the certificate of coverage that is in force at the time when the insurance policy is terminated, **corresponding to the percentage value assigned to the degree of the permanent disability stated in this Clause,** also subject to Clause II.9. of these Special Conditions.

The percentage values corresponding to the rate of the progressive benefit with respect to the degree of the permanent disability:

If the degree of the permanent impairment is under 26%, the percentage value corresponding to the rate of the benefit shall be identical to the extent of the impairment; in other cases the said percentage value corresponding to the degree of the permanent impairment shall be the following:

degree of impairment → benefit %	degree of impairment → benefit %	degree of impairment → benefit %	degree of impairment → benefit %	degree of impairment → benefit %
26% → 27%	41% → 57%	56% → 93%	71% → 138%	86% → 183%
27% → 29%	42% → 59%	57% → 96%	72% → 141%	87% → 186%
28% → 31%	43% → 61%	58% → 99%	73% → 144%	88% → 189%
29% → 33%	44% → 63%	59% → 102%	74% → 147%	89% → 192%
30% → 35%	45% → 65%	60% → 105%	75% → 150%	90% → 195%
31% → 37%	46% → 67%	61% → 108%	76% → 153%	91% → 198%
32% → 39%	47% → 69%	62% → 111%	77% → 156%	92% → 201%
33% → 41%	48% → 71%	63% → 114%	78% → 159%	93% → 204%
34% → 43%	49% → 73%	64% → 117%	79% → 162%	94% → 207%
35% → 45%	50% → 75%	65% → 120%	80% → 165%	95% → 210%
36% → 47%	51% → 78%	66% → 123%	81% → 168%	96% → 213%
37% → 49%	52% → 81%	67% → 126%	82% → 171%	97% → 216%
38% → 51%	53% → 84%	68% → 129%	83% → 174%	98% → 219%
39% → 53%	54% → 87%	69% → 132%	84% → 177%	99% → 222%
40% → 55%	55% → 90%	70% → 135%	85% → 180%	100% → 225%

II.3. The **extent (degree) of any permanent disability** on which the insurance claim is based, **shall be confirmed by the insurance company's medical examiner pursuant to the table in Schedule C which shall form an integral part of the General Conditions.**

II.4. If the extent of the disability **cannot be established on the basis of the table,** the insurance benefit shall be determined by a **medical review of any loss or abnormality of physiological, psychological, or anatomical structure or function.**

Organs or body parts injured permanently before the date of the accident shall be excluded from the insurance coverage up to the extent of the former injury.

The extent of permanent impairment determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (permanent impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the permanent impairment by the insurance company's medical examiner, or for specifying the permanent disability benefit amount payable by the insurance company. **Furthermore, the advice or resolution of any other medical board shall not be binding on the insurance company when determining the permanent state of the disability or the degree of permanent partial disability.**

II.5. The **extent** of the **permanent disability** resulting from any one insured event **may not be higher than 100%.**

II.6. **If the insured dies before his/her impairment is stabilized, the benefit shall be determined on the basis of the extent of the impairment confirmed by the insurance company's medical examiner on the basis of the documents of the last medical examination.**

II.7. **No permanent disability benefit may be claimed if the insured dies within 15 days after the accident.**

II.8. If the **insurance company has already established that the claim for an insurance benefit is grounded** but the **benefit amount cannot be determined yet,** the **insured may require** that the insurance company would pay the **minimum benefit amount** due under the given coverage.

II.9. **If the insurance company has already made an insurance benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file supplementary insurance claims,** supported by all the necessary medical documents in proof of the deterioration of the insured's condition despite appropriate medical treatment, **once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim,** and may request that **his/her condition be reassessed** and the **degree of the permanent impairment be determined again.** Based on the findings of the medical review, the insurance company shall pay the insurance benefit in accordance with Clause II.2 of these Special Conditions, on the understanding that **benefit payouts made earlier on the insured event specified above shall be deducted from any later benefit payout.**

Even in such a case, the extent of the permanent disability resulting from the same insured event **may not be higher than 100%.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment.
b) the accident & injury report, if available,
c) the result of the blood alcohol and/or drug test, if available,
d) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate,
e) other documents required for the full clarification of the circumstances of the accident.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.7. If the insurance claim is grounded, the **insurance company will settle** the insurance claim **within the following deadlines:**

a) if the claim is for a permanent disability benefit and the **permanent impairment has been medically confirmed,** the insurance company shall make the payout **within 15 days upon receipt of the last document** required for the assessment of the insurance claim,
b) **in other cases,** the insurance company shall make the payout **within 15 days after the impairment is confirmed to be permanent,** or **within 15 days after the expiry of 4 years following the accident.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for the permanent disability benefit (accidents) in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Bone Fracture Insurance (KBCST/02017)

These Special Conditions set out the standard terms and conditions for the **bone fracture insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the coverage period and **as a result of which the insured suffers a bone fracture, including incomplete fractures.** For the purposes of these Special Conditions, **a tooth fracture does not qualify as bone fracture.**

I.2. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

If an insured event occurs, the insurance company shall pay out the respective **sum insured specified on the insurance policy** effective as at the date of the insured event, **irrespective of the number of fractures per accident.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the radiology (x-ray) report or medical certificate confirming the fracture,
b) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
c) the accident & injury report, if available,
d) the result of the blood alcohol and/or drug test, if available,
e) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a bone fracture benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Insurance for Injuries Healing over 14 or 28 Days (KBSER/02017)

These Special Conditions set out the standard terms and conditions for the **insurance cover for injuries healing over 14 or 28 days available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the coverage period and **as a result of which the insured suffers injuries healing over 14 or 28 days.** For the purposes of these Special Conditions, an injury will be regarded to **heal over 14 or 28 days** if as a result of such accident-related injury the **insured becomes incapacitate**d or a minor or student insured is released by a physician from the obligation to go to school **for at least 14 or 28 consecutive calendar days within one year of the date of the accident and there is medical proof in support of such fact.**

I.2. **Subsequent, multiple healing periods arising from the same accident shall not be added up.**

I.3. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If an insured event occurs, the insurance company shall settle the claim on the basis of number of benefit days (14 or 28 days) stated on the insurance application, and shall the pay **the sum insured specified on the certificate of coverage effective** as of the date of the insured event to the beneficiary.

II.2. **The sum insured may only be paid once with respect to any one accident.**

II.3. The benefit payable is determined on the basis of the number of days stated on the insurance application.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the medical certificate in proof of a healing period over 14 or 28 days,
b) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
c) the accident & injury report, if available,
d) the result of the blood alcohol and/or drug test, if available,
e) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a benefit for injuries healing over 28 days in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Accident Expense Insurance (KBKTS/02017)

These Special Conditions set out the standard terms and conditions for the **accident expense cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **an accident** (Clause IX.1. of the General Conditions) which occurs during the coverage period, as a result of which the **insured incurs accident expenses as defined in Clause I.2.**

I.2. **Accident expenses** mean the following **costs incurred** in relation to the accident **and certified by invoices issued in Hungary:**

a) **rescue costs** which are necessarily incurred when the insured suffers an accident and as a result, the injured insured needs to be rescued, or the insured dies in the accident, and the body can only be reached through rescue manoeuvers,

b) **transporting costs,** which are necessarily incurred if the insured suffers an accident and needs to be transported to the nearest medical facility, hospital or doctor's surgery suitable for his/her treatment; or if the insured is repatriated home from the medical facility on the physician's advice on no more than one occasion; or if the insured dies in the accident, and the body is transported from the scene of the accident (the insurance does not cover costs of transporting the insured for wound dressing, removing sutures, or other medical tests),

c) **repair costs of teeth, partial dentures, tooth crowns, bridges and other dental aids injured or damaged in the accident** – except removable complete dentures – provided that the injury/damage is demonstrably the result of the accident.
Accident expenses shall not include the repair costs of a tooth, partial denture, tooth crowns, bridges and other dental aids by reason of a fault or lack of conformity which existed prior to the accident, nor the replacement or repair costs of the removable complete denture of the insured.

d) purchase cost of d**urable medical equipment,** or purchase cost of other supplies or materials (e.g.: dressing, pharmaceuticals) in quantities sufficient for the medical treatment.
Accident expenses does not include the purchase cost of durable medical equipment if it is not directly related to the accident (e.g.: if existing durable medical equipment needs to be purchased once again because it is stolen, damaged or needs quality replacement). The necessity for durable medical equipment may be challenged by the insurance company's medical examiner. For the purposes of these Special Conditions, durable medical equipment means any equipment so defined in effective legislation. Accident-related costs shall not include travel and accommodation costs of bath therapies and vacations.

I.3. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

The insurance company shall reimburse the accident expenses defined under Clause I.2 of these policy conditions up to the amount of the sum insured specified on the certificate of coverage effective as of the time of the accident, provided that **they are incurred within 2 years following the date of the accident, and cannot otherwise be recovered.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **original invoices issued to the name of the insured, certifying payments,**

III.3.3. **and a copy of the following documents:**

a) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,

b) the accident & injury report, if available,

c) the result of the blood alcohol and/or drug test, if available,

d) **in the event of a road traffic accident,** in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate,

e) other documents required for the full clarification of the circumstances of the accident

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for an accident expenses benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Hospital Daily Allowance Insurance (Accidents) (KBKNT/02017)

These Special Conditions set out the standard terms and conditions for the **hospital daily allowance (accidents) cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **an accident** (Clause IX.1. of the General Conditions) **which occurs during the coverage period,** as a result of which the **insured is hospitalized** (Clause IX.2. of the General Conditions) provided that such hospitalization is medically required.

I.2. For the purposes of this insurance, **hospitalization** is provided when a person is hospitalized in a medical facility for several days to receive medical care, and the person **spends every night during his hospitalization, between admission and discharge, in the hospital in connection with the medical treatment.** The insured is hospitalized for multiple days if his/her discharge from the hospital is on a later day than that of his/her admission. In the event of hospitalization, for the purpose of determining the benefit payable (Chapter II of these Special Conditions), the first day of hospitalization shall be the date of admission, and the last day of hospitalization shall be the date of discharge.

I.3. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. The insurance shall pay a benefit for each day of the **hospitalization** (Clause I.2. of these Special Conditions) of the insured needed to avert the medical consequences of an accident which have developed **within two years after the date of the insured's accident.**

II.2. The **amount of the benefit payable** for the insured's inpatient hospital care is the **sum insured specified in the certificate of coverage** in force during the hospitalization **multiplied by the number of hospitalization days.**

If the insured suffers an accident while the insurance policy is in force but **receives inpatient hospital care** due to such accident **only after the termination of this insurance policy,** the benefit payout will be determined on the basis of the **sum insured specified in the last certificate of coverage in force.**

II.3. **If the insured hospital treatment is provided at the medical facility's intensive care unit (ICU), the insurance pays out 200% of the sum insured for each day of hospital treatment at the intensive care unit.**

For the purposes of these policy conditions intensive care unit means only such a hospital department which is authorized to provide intensive care pursuant to its name, operations and operating licence.

For the purposes of these policy conditions, treatment provided in a sub-intensive care unit or in a post-anesthesia care unit does not mean treatment in an intensive care unit.

II.4. **If** the insurance anniversary is during a period when the insured receives inpatient care (hospitalization), and the **insurance policy is subject to annual indexation** (Clause IV.7. of the General Conditions), the insurance company **shall apply the increased sum insured** to determine the daily cash benefit with respect to such hospitalization after the insurance anniversary of the policy, in accordance with the rules of annual indexation.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary,
b) the discharge summary issued by the intensive care unit, if such treatment was provided,
c) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
d) the accident & injury report, if available,
e) the result of the blood alcohol and/or drug test, if available,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for the hospital daily benefit (accidents) in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Surgery Insurance (Accidents) (KBMÜT/02017)

These Special Conditions set out the standard terms and conditions for the **surgery insurance (accidents) cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **an accident** (Clause IX.1. of the General Conditions) which occurs during the coverage period, as a result of which the **insured needs surgery** (Clause IX.2. of the General Conditions) provided that such surgery is medically required.

I.2. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If the insured in injured in an accident, the insurance covers the **surgeries of the insured required to treat the medical consequences of the accident within two years after the occurrence of such accident.**

II.2. The benefit payable is a **percentage of the sum insured stated in the certificate of coverage** effective as of the date of the surgery, **corresponding to the category of the surgical procedure performed.**

If the surgery is performed beyond the coverage period but within two years of the date of the insured event, the benefit payout will be determined on the basis of the **sum insured stated in the most current effective certificate of coverage.**

II.3. The **abstracted list of surgeries** which contains the classification of surgeries (Clause IX.2. of the General Conditions) is **attached to the General Conditions as Schedule D.** The abstracted list of surgeries contains the name of surgical procedures, their classification and the benefit % applicable to the surgeries which belong to different payment groups.

II.4. If **several surgeries are performed on the same day or during the same procedure,** the insurance company **will determine the amount of the benefit payout on the basis of the surgery with the highest percentage classification.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary,
b) the operative report, if available,
c) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
d) the accident & injury report, if available,
e) the result of the blood alcohol and/or drug test, if available,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the reasonableness of the insured's surgery and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a surgery benefit arising from accidents in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Accidental Burn Injury Insurance (KBÉGS/02017)

These Special Conditions set out the standard terms and conditions for the **accidental burn injury insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an accident (Clause IX.1 of the General Conditions) which occurs during the coverage period and **as a result of which the insured suffers burn injuries.**

I.2. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If an insured event occurs, the **insurance company shall pay the proportional part of the sum insured stated in the certificate of coverage in force at the time of the accident, which corresponds to the severity of the burns.**

II.2. **The benefit is determined as a % of the sum insured depending on the degree of the burns and the affected body surface area as specified in the following table:**

Depth	Body surface area			
	10–19%	20–49%	50–79%	over 80%
First degree	–	–	–	–
Second degree	–	10%	25%	40%
Third degree	20%	40%	100%	160%
Fourth degree	40%	80%	200%	200%

II.3. **If the insured suffers multiple burns with different degrees and/or affecting different % of the body surface as a result of a single insured event, the insurance company determines the benefit payout by adding up the % values applicable to the different burns, and by taking into account the burn of highest severity.**

II.4. If the insured is confirmed to have suffered at least third-degree burns on his face (facial skeleton and the neurocranium, including the ears and the neck areas below the chin) covering at least 2% of his/her body surface as a direct result of the burn injuries, the insurance pays out 200% of the sum insured specified in the certificate of coverage effective at the time of the insured event for the burn injuries.

II.5. If evidence supports that the **insured dies directly of the burns,** the insurance company shall pay the **death beneficiary 200% of the sum insured,** irrespective of the severity of the burns.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to** those set out in Clause V.3.2 of the General Conditions governing the insurance policy:

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary or the outpatient records, if as a result of the burns the insured requires in-patient hospital care or outpatient care,
b) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
c) the accident & injury report, if available,
d) the result of the blood alcohol and/or drug test, if available,
e) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.3.3. when the notice of a **death claim** is submitted, a copy of the following documents shall also be attached:

a) cause of death medical certificate /hospital course summary,
b) the insured's certificate of death,

c) **the document in proof of the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy,
d) other documents necessary for the clarification of all the circumstances of the death or accident.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a burn injuries benefit arising from an accident in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Accidental Death Insurance (Road Traffic Accidents) (KKHAT/02017)

These Special Conditions set out the standard terms and conditions for the **accidental death insurance (road accidents) cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is a **road traffic accident** (within the meaning of Clause IX.1 of the General Conditions) which occurs during the coverage period, **as a result of which the insured dies within one year after such accident.**

I.2. The date of the insured event is the **date of the road traffic accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. **If an insured event occurs,** the insurance company shall pay out the sum insured specified in the certificate of coverage that is in force at the time when the insured dies, provided that the claim is grounded.

II.2. **If the insured dies after the termination of this insurance policy as a result of a road traffic accident** which occurred while the insurance policy was in force, but the insured's death is within one year after the date of such road traffic accident (insured event), the insurance benefit payout will be determined on the basis of **the sum insured stated in the most current effective certificate of coverage.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2. of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) cause of death medical certificate / hospital course summary,
b) autopsy report,
c) the insured's certificate of death,
d) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment, e) the official on-site report of the passenger carrier company, the police report, or the workplace accident & injury report, if available,
f) the result of the blood alcohol and/or drug test, if available,
g) if the insured **was injured or died** as the **driver of a vehicle,** a copy of the driver's license and the vehicle registration certificate.
h) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance), provided that the beneficiary was not named in the insurance policy.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a death claim arising from road traffic accidents in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Permanent Disability Insurance (Road Traffic Accidents) (KKR0K/02017)

These Special Conditions set out the standard terms and conditions for the **permanent disability insurance (road traffic accidents) cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is a **road traffic accident** (within the meaning of Clause IX.1 of the General Conditions) which occurs during the coverage period, **as a result of which the insured suffers permanent disability.**

I.2. **Disability** means a **loss or impairment of a physical and/or mental function which impedes the ordinary pursuits of life.**

I.3. **Disability shall be permanent** if the impairment of the insured is medically **fixed, lasting and stable. If the degree of the impairment is continuously changing,** but 2 years have passed since the date of the accident, then **after the expiry of the 2 years, the insurance company's medical examiner shall be entitled to determine the degree of the confirmed impairment,** which the insurance company shall regard as **permanent disability arising from accident** for the purposes of the insurance company's payment of insurance benefits and with respect to the amount of such benefits. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference for establishing permanent impairment.** No adverse aesthetic effect or other **(social, financial, etc.) detriment** arising from or in relation to the accident **shall in itself be grounds for an insurance claim** with respect to permanent disability.

I.4. The date of the **insured event is the date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. **A claim for disability benefit may only be paid if the impairment is permanent** (Clause I.3. of these Special Conditions).

II.2. **If an insured event occurs, the benefit payout** that the insurance company will make will be the **percentage of the sum insured specified in the policy** that is in force at the time when the permanent impairment is established, or in the absence thereof the sum insured specified in the policy that was in force at the time when the insurance policy was terminated, **identical to the degree of the permanent impairment.**

II.3. The **extent (degree) of any permanent disability** on which the insurance claim is based, **shall be confirmed by the insurance company's medical examiner pursuant to the table in Schedule C which shall form an integral part of the General Conditions.**

II.4. If the extent of the disability **cannot be established on the basis of the table,** the insurance benefit shall be determined by a **medical review of any loss or abnormality of physiological, psychological, or anatomical structure or function.**

Organs or body parts injured permanently before the date of the accident shall be excluded from the insurance coverage up to the extent of the former injury.

The extent of permanent impairment determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (permanent impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the permanent impairment by the insurance company's medical examiner, or for specifying the permanent disability benefit amount payable by the insurance company. **Furthermore, the advice or resolution of any other medical board shall not be binding on the insurance company when determining the permanent state of the disability or the degree of permanent partial disability.**

II.5. The **extent** of the **permanent disability** resulting from any one insured event **may not be higher than 100%.**

II.6. **If the insured dies before his/her impairment is stabilized, the benefit shall be determined on the basis of the extent of the impairment confirmed by the insurance company's medical examiner on the basis of the documents of the last medical examination.**

II.7. **No benefit may be claimed** on permanent health impairment **if the insured dies within 15 days after the accident.**

II.8. If the **insurance company has already established that the claim for an insurance benefit is grounded** but the **benefit amount cannot be determined yet,** the **insured may require** that the insurance company would pay the **minimum benefit amount** due under the given coverage.

II.9. **If the insurance company has already made an insurance benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file supplementary insurance claims,** supported by all the necessary medical documents in proof of the deterioration of the insured's condition despite appropriate medical treatment, **once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim,** and may request that **his/her condition be reassessed and the degree of the permanent impairment be determined again.** Based on the findings of the medical review, the insurance company shall pay the insurance benefit in accordance with Clause II.2 of these Special Conditions, on the understanding that **benefit payouts made earlier on the insured event specified above shall be deducted from any later benefit payout.**

Even in such a case, the extent of the permanent disability resulting from the same insured event **may not be higher than 100%.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment.
b) the official on-site report of the passenger carrier company, the police report, or the workplace accident & injury report, if available,
c) the result of the blood alcohol and/or drug test, if available,
d) if the insured **was injured** as the **driver of a vehicle,** a copy of the driver's license and the vehicle registration certificate.
e) other documents required for the full clarification of the circumstances of the accident.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.7. If the insurance claim is grounded, the **insurance company will settle** the insurance claim **within the following deadlines:**

a) if the claim is for a **permanent disability benefit and the permanent impairment has been medically confirmed,** the insurance company shall make the payout **within 15 days upon receipt of the last document** required for the assessment of the insurance claim,
b) in other cases, the insurance company shall make the payout **within 15 days after the impairment is confirmed to be permanent, or within 15 days after the expiry of 4 years following the accident.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a permanent disability benefit arising from road traffic accidents in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Damaged Luggage and Clothes Insurance (KBPGY/02017)

These Special Conditions set out the standard terms and conditions for the **damaged luggage and clothing insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (Clause IX.1 of the General Conditions) which occurs during the coverage period and **as a result of which the insured suffers injuries that require medical attention and heal over 8 days,** while the **insured's clothing or luggage is also damaged** as a result of the accident.

I.2. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

The insurance covers the following costs and expenses **up to the sum insured specified on the certificate of coverage effective** as of the date of the insured event, provided that they cannot otherwise be recovered:

a) repair or cleaning costs of any clothes or luggage that is damaged in the accident, or the value of the damaged clothes or luggage as at the time of the accident if the clothes or luggage is damaged to an extent which may not be repaired,
b) the costs of replacing the documents damaged in the accident.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to** those set out in Clause V.3.2 of the General Conditions governing the insurance policy:

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **original invoices issued to the name of the insured, certifying payments** (for repair or cleaning),

III.3.3. **and a copy of the following documents:**

a) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
b) the accident & injury report, if available,
c) the result of the blood alcohol and/or drug test, if available,
d) in the case of a road traffic accident, in addition to the above:
   – the police report,
   – if the insured **was injured** or died in a road traffic accident as a **driver of a vehicle,** a copy of the driver's license and of the vehicle's traffic license,
e) other documents required for the full clarification of the circumstances of the accident.

III.4. During the settlement of the claim, the insurance company may require that the damaged or repaired luggage, or piece of clothing be presented.

III.5. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.6. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.7. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EVENTS EXCLUDED FROM INSURANCE COVERAGE

IV.1. The insurance does not cover the cases set out in Chapter VII. of the General Conditions.

IV.2. This insurance does not cover furthermore:

a) jewelry (including watches of a value higher than HUF 15 000), precious metals,
b) works of fine art, collections,
c) cash or cash replacement instruments, bank notes, checks, savings books, and other securities,
d) musical instruments
e) precious fur,

f) glasses,
g) vehicle accessories and parts, tools,
h) transportation tickets,
i) sports equipment,
j) electronic goods and accessories, including in particular desktop personal computers, notebooks, radios, photo cameras, televisions, cell phones, recorders or players (e.g.: video cameras, VCRs, CD players, DVD players etc.), portable home entertainment equipment and communication tools,
k) as well as objects and their accessories of a value exceeding 50 000 HUF each at the time of their purchase.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Recovery Insurance (Accidents) (KBTÁM/02017)

These Special Conditions set out the standard terms and conditions for the **recovery insurance cover (accidents) available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an accident (Clause IX.1. of the General Conditions) which occurs during the coverage period, as a result of which the insured is hospitalized (Clause IX.2. of the General Conditions) within 30 days of the accident.

I.2. For the purposes of this insurance, hospitalization shall be provided for any person who is hospitalized in a medical service provider institution for several days to receive medical attention, and the person spends every night during his hospitalization, between admission and release, in such institution in connection with the medical treatment. The insured is hospitalized for multiple days if his/her discharge from the hospital is on a later day than that of his/her admission. In the event of hospitalization, for the purpose of determining the benefit payable (Chapter II of these Special Conditions), the first day of hospitalization shall be the date of admission, and the last day of hospitalization shall be the date of discharge.

I.3. The date of the insured event is the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If an insured event occurs, the insurance pays out the following insurance benefits:

II.1.1. If the insured is hospitalized within 30 days of the accident, the insurance company pays the **sum insured** stated on the certificate of coverage effective as of the date of the accident **multiplied by the number of hospitalization days as the insurance benefit.**

II.1.2. If the insured hospital treatment is provided at the medical facility's intensive care unit (ICU), **the insurance pays out 200% of the sum insured for each day of hospital treatment at the intensive care unit.**

For the purposes of these policy conditions intensive care unit means only such a hospital department which is authorized to provide intensive care pursuant to its name, operations and operating licence. For the purposes of these policy conditions, treatment provided in a sub-intensive care unit or in a post-anesthesia care unit does not mean treatment in an intensive care unit.

II.1.3. The amount of the benefit is **50% of the sum insured calculated in accordance with Clause II.1.1. on each day of the incapacity period** following the insured's hospitalization. The insurance benefit may only be claimed and paid out on the incapacity period following the insured's hospitalization if the insured was hospitalized before the incapacity period and the incapacity period of home recovery commences immediately after the insured is discharged from the hospital.

II.2. No benefit may be claimed on the first day of the continuous hospitalization and on the number of subsequent days specified in the policy (on the insurance application) (hereinafter: elimination period), save for the case when the period of continuous hospitalization exceeds the elimination period specified in the insurance policy, in which case the insurance company will pay the sum insured stated in the certificate of coverage effective on the given day on each day of the hospitalization, including the elimination period.

II.3. When calculating the benefit payout, the sum insured stated in the most current effective certificate of coverage applicable to the insured shall be used if the insured suffered the accident during the coverage period but the hospitalization only commenced after the insurance policy or the insured's coverage was terminated.

II.4. The annual indexation of the policy after the insurance anniversary will not modify the benefit payment under this insurance.

II.5. The benefit may be claimed only once and for a maximum of 30 days in respect of any one insured event arising from an accident.

II.6. Benefits may be claimed by any one insured on insured events arising from no more than two different accidents in any one policy year.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2. of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary,
b) the discharge summary issued by the intensive care unit, if such treatment was provided,
c) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
d) the accident & injury report, if available,

e) the result of the blood alcohol and/or drug test, if available,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate,
g) the standard medical certificate of incapacity issued by a physician who is authorized to confirm and certify incapacity pursuant to effective legislation (Medical Certificate of Incapacity), h) in the event of incapacity: pursuant to effective legislation, in the case of incapacity a copy of the Medical Certificate of Incapacity issued by an approved physician in proof of the insured's continuous incapacity shall be submitted to the insurance company containing reference to the policy number within 14 days after the certificate is issued (hereinafter: Medical Certificate of Continuous Incapacity).

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3 of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for the recovery insurance benefit (accidents) in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Incapacity Insurance (Accidents) (KBKEK/02017)

These special conditions set out the standard terms and conditions for the **incapacity insurance (accidents) covers available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. ELIGIBILITY CONDITIONS FOR INCAPACITY INSURANCE (ACCIDENTS)

I.1. Pursuant to these Special Conditions, **no natural person without eligibility to Statutory Sick Pay (SSP)** under the national health insurance scheme **may be covered under this accident-related incapacity insurance.**

I.2. The **policyholder/insured is required to notify** the insurance company **within 15 days if the eligibility to a statutory sick pay** under the national health insurance scheme **terminates during the policy period.** In such a case the accident-related incapacity insurance coverage of the particular insured shall terminate on the first day of the month following the date when the insured's eligibility for statutory sick pay is terminated.

I.3. If the Incapacity Insurance (Accidents) cover of a policy is terminated with respect to a particular insured in accordance with Clause I.2., the cover may be reinstated pursuant to a written request by the policyholder and the insured, with the insurance company's permission when the cause of the termination no longer exists, and after the insurance company completed medical underwriting.

II. INSURED EVENT

II.1. The insured event is the **accident** (Clause IX.1. of the General Conditions) which occurs during the coverage period and **as a result of which the insured becomes incapacitated in his/her own right and is granted a statutory sick pay in Hungary in accordance with effective legislation,** and the incapacity is certified by a licensed physician who is authorized to assess and certify the incapacity status.

II.2. The date of the insured event is the **date of the accident.**

III. INSURANCE BENEFITS AND COVERED SERVICES

III.1. The insurance pays a benefit on the **insured's incapacity period due to medical consequences of the insured's accident which may arise within two years after the date of the accident,** subject to the provisions of Clauses III.2. and III.3. of these conditions.

III.2. **The insurance does not pay a benefit for the first day of the continuous period of incapacity and for the number of days specified in the policy (or the insurance application) (hereinafter: elimination period).**

III.3. **Once the elimination period is over,** the insurance company will **pay out the sum insured specified in the certificate of coverage current as of the particular day for all additional days.**

If the insured becomes incapacitated (partially or fully) as a result of an accident **beyond the end of the coverage period,** the benefit payout will be determined on the basis of the **sum insured specified in the most current effective certificate of coverage.**

III.4. If the insurance anniversary falls within a period when the insured is certifiably incapacitated, and the **insurance policy is taken out with annual indexation** (Clause IV.7. of the General Conditions), the insurance company shall **pay an increased benefit** in accordance with the rules of annual indexation, **after the insurance anniversary.**

III.5. The insurance pays the benefit with respect to any one accident for a maximum of 150 days within two years of the date of the accident.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

IV.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

IV.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

IV.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

IV.3.2. **and a copy of the following documents:**

a) the standard medical certificate of incapacity issued by a physician who is authorized to confirm and certify incapacity pursuant to effective legislation (Medical Certificate of Incapacity (Pregnancy)),
b) if hospital care was received: the hospital discharge summary, within 15 days after the end of the hospital treatment,
c) all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment.
d) the accident & injury report, if available,
e) the result of the blood alcohol and/or drug test, if available,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

IV.3.3. **in any continuing period of incapacity:**

a) the documents listed in Clauses IV.3.1 and IV.3.2. d), e), f) are required to be submitted only with the first notice of claim,

b) a copy of the medical certificate on the insured's continuing period of incapacity issued by a health care provider authorized to assess incapacity pursuant to effective legislation, shall be submitted to the insurance company within 14 days after it is issued, with reference to the policy number (hereinafter: medical certificate on a continuing period of incapacity);

c) new medical documents produced on the insured's medical conditions shall be submitted to the insurance company by the insured at least once in every 60 days.

IV.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV.5. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis** of the findings of such review.

IV.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

V. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

V.1. In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for an incapacity benefit arising from accidents in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

V.2. In addition to the exclusions set forth in the General Conditions, the insurance coverage shall not apply to the insured's incapacity if during such incapacity period the insured pursues gainful activities.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Hospital Daily Allowance Insurance (KEKNT/02017)

These Special Conditions set out the standard terms and conditions for the **hospital daily allowance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **the insured's sudden illness which is unprecedented relative to the commencement of the insurance coverage or an accident** (Clauses IX.1. and IX.2 of the General Conditions) **which occurs during the coverage period,** as a result of which the **insured receives inpatient hospital care** (Clause IX.2. of the General Conditions) provided that the hospitalization is medically required.

I.2. For the purposes of this insurance, **hospitalization** is provided when a person is hospitalized in a medical facility for several days to receive medical care, and the person **spends every night during his hospitalization, between admission and discharge, in the hospital in connection with the medical treatment.** The insured is hospitalized for multiple days if his/her discharge from the hospital is on a later day than that of his/her admission. In the event of hospitalization, for the purpose of determining the benefit payable (Chapter II of these Special Conditions), the first day of hospitalization shall be the date of admission, and the last day of hospitalization shall be the date of discharge.

I.3. If the **insured is admitted to hospital because of illness, the date of the insured event** is the first day of the inpatient hospital care (hospitalization); if the insured is admitted to hospital because of an **accident,** the date of the insured event shall be the **date of the accident.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. In the event of the **insured's illness,** the insurance company shall pay the insurance benefit for **each day of the insured's inpatient hospital care** (Clause I.2. of the Special Conditions) **during the coverage period.** If the insured **suffers an accident** during the coverage period, the insurance company will pay an insurance benefit for **each day of the insured's inpatient hospital care** (Clause I.2. of the Special Conditions) required to treat the medical consequences of the accident **within two years after the date of the insured's accident.**

II.2. The **amount of the benefit payable** for the insured's inpatient hospital care is the **sum insured specified in the policy** in force during the hospitalization **multiplied by the number of hospitalization days.**

If the insured suffers an accident while the insurance policy is in force but is **hospitalized** due to such accident **only beyond the coverage period,** the insurance benefit payout will be determined on the basis of the **sum insured stated in the most current effective certificate of coverage.**

II.3. **If the insured hospital treatment is provided at the medical facility's intensive care unit (ICU), the insurance pays out 200% of the sum insured for each day of hospital treatment at the intensive care unit.**

For the purposes of these policy conditions intensive care unit means only such a hospital department which is authorized to provide intensive care pursuant to its name, operations and operating licence.

For the purposes of these policy conditions, treatment provided in a sub-intensive care unit or in a post-anesthesia care unit does not mean treatment in an intensive care unit.

II.4. **If** the insurance anniversary is during a period when the insured receives inpatient care (hospitalization), and the **insurance policy is subject to annual indexation** (Clause IV.7. of the General Conditions), the insurance company **shall apply the increased sum insured** to determine the daily cash benefit with respect to such hospitalization **after the insurance anniversary** of the policy, in accordance with the rules of annual indexation.

II.5. **If the insurance claim is grounded, the insurance company shall pay the insurance benefit for a maximum of 120 days of hospitalization within any one policy year.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary,
b) the discharge summary issued by the intensive care unit, if such treatment was provided;
c) in the event of hospitalization due to an accident, additionally:
   - all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
   - the accident & injury report, if available,
   - the result of the blood alcohol and/or drug test, if available,

d) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a hospital daily benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Surgery Insurance (KEMÜT/02017)

These Special Conditions set out the standard terms and conditions for the **surgery insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **the insured's sudden illness which is unprecedented relative to the commencement of the insurance coverage or an accident** (Clause IX.1. of the General Conditions) **which occurs during the coverage period,** as a result of which the **insured needs surgery** (Clause IX.2. of the General Conditions) provided that the surgery is a medical necessity.

I.2. The **date** of the insured event is the **date of the surgery** if such **surgery is required to treat the insured's illness,** or the **date of the accident, if a surgery is required because of an accident of the insured.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. **If the insured becomes ill,** the insurance covers **the insured's surgeries while the insurance policy is in force,** and if the insured in **injured in an accident,** the insurance covers the **surgeries of the insured required** to treat the medical consequences of the accident **within two years after the occurrence of such accident.**

II.2. The benefit payable is a **percentage of the sum insured stated in the certificate of coverage** effective as of the date of the surgery, **corresponding to the category of the surgical procedure performed.**

II.3. **If a surgery required as a result of the insured's accident is performed after the coverage period is over but within two years of the date of the insured event,** the benefit payout will be determined on the basis of the **sum insured specified in the last policy in force.**

II.4. The **abstracted list of surgeries** which contains the classification of surgeries (Clause IX.2. of the General Conditions) is **attached to the General Conditions as Schedule D.** The abstracted list of surgeries contains the name of surgical procedures, their classification and the benefit % applicable to the surgeries which belong to different payment groups.

II.5. **If several surgeries are performed on the same day or during the same procedure, the insurance company will determine the amount of the benefit payout on the basis of the surgery with the highest percentage classification.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.3 of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) the hospital discharge summary,
b) the operative report, if available,
c) additionally, if the insured event is the **direct result of an accident:**
   - all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
   - the accident & injury report, if available,
   - the result of the blood alcohol and/or drug test,
d) **in the case of a road traffic accident,** in addition to the above:
   - the police report, if available,
   - if the insured **was injured** in a road traffic accident as the **driver of a vehicle,** the driver's license and the vehicle registration certificate.

III.4. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

III.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for the surgery benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Partial Disability Insurance (exceeding 69%) (KEOEP/12017)

These Special Conditions set out the standard terms and conditions for the **partial (exceeding 69%) disability insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

For the purposes of these policy conditions, the term 'National Institute of Medical Experts' means any official body authorized under effective legislation to determine a degree of disability (physical or mental impairment).

I. INSURED

Pursuant to these Special Conditions, the insurance **policy may not be taken out to cover** natural persons who – **prior to the conclusion of the insurance policy (signing the insurance application)**

a) **have been granted pension benefits on their own right, or any other benefit/allowance** (e.g.: disability, accident) for physical or mental impairment or impaired earning capacity pursuant to the expert opinion of the National Institute of Medical Experts, or
b) **have already applied for** the determination or review of the extent of a permanent impairment (disability) or loss of earning capacity with the **competent authority.**

II. INSURED EVENT

II.1. The insured event is a sudden, unexpected development of an **illness** without precedent conditions prior to the commencement of the insurance coverage, or an **accident** during the coverage period, **as a result of which the National Institute of Medical Experts** determines **in its expert's opinion that the insured has suffered permanent impairment to an extent exceeding 69 percent,** provided that **the insured submits the application for the determination of the permanent disability while the insurance policy is in force.**

II.2. The **date** of the insured event is the **issue date of the expert's opinion of the National Institute of Medical Experts.**

II.3. If the execution date of expert's opinion of the National Institute of Medical Experts is a later date than the cancellation date of the insurance, the insurance company shall only make a payout if the application for the verification of the insured's permanent disability has been submitted to the competent authority prior to the termination of the insurance.

III. INSURANCE BENEFITS AND COVERED SERVICES

III.1. If an insured event occurs, the insurance company shall pay the **sum insured stated in the certificate of coverage** in force as at the date when the professional opinion of the National Board of Medical Experts is issued, and at the same time the insurance cover under these Special Conditions shall terminate with respect to the particular insured.

If the execution date of expert's opinion of the National Institute of Medical Experts is a later date than the termination of the insurance, the insurance company will determine the benefit payout on the basis of the **sum insured stated in the most current effective certificate of coverage.**

III.2. **If an insured event occurs, the insurance company is entitled to charge the insurance premium calculated for the insured concerned until the end of the policy year in which the insured event occurred.**

III.3. If the insurance policy has been taken out with a waiting period (Clause II.3.5. of the General Conditions) and the insured is diagnosed with **an illness which is not in any way caused by an accident** before the end of such waiting period and such illness leads to the insured's permanent impairment to an extent exceeding 69 percent, the insurance company shall **refund to the policyholder all insurance premiums paid for the insurance coverage** subject to these Special Conditions with respect to the particular insured.

Once the premium is refunded, the insurance coverage governed by these Special Conditions shall **terminate** with respect to the particular insured **retroactively** to the commencement of this risk coverage.

III.4. If the insurance policy has been taken out with a waiting period and the insured applies for the determination of his/her permanent impairment at the competent authority **during such waiting period,** the insurance company shall refund to the policyholder all insurance premiums paid for the insurance coverage subject to these Special Conditions with respect to the particular insured, save for the case if the ground for the claim is a result of a documented accident which occurred after the inception date of the insurance coverage. **Once the premium is refunded,** the insurance coverage governed by these Special Conditions shall **terminate** with respect to the particular insured **retroactively** to the commencement of this risk coverage.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

IV.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

IV.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

IV.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

IV.3.2. **and a copy of the following documents:**

a) **The expert opinion of the National Institute of Medical Experts.**

b) if the expert's opinion of the National Institute of Medical Experts is issued after the insurance is terminated, the **document evidencing the date when the application** for the determination of the insured's permanent impairment of a degree exceeding 69 percent **was submitted,**

c) a certification from the treating physician or the general practitioner describing the primary medical cause(s) of the insured event, as well as the exact date of the first diagnosis and the progression of the illness,

d) if the permanent impairment of an extent of more than 69 percent is **directly arising from the accident,** then
   – all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
   – the accident & injury report, or in the case of a workplace accident, the workplace accident & injury report, if available,

e) **in the case of a road traffic accident,** in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

IV.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

IV.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

V. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for benefits specified in these Special Conditions in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

VI. TERMINATION OF INSURANCE SUBJECT TO THESE CONDITIONS

The insurance coverage under a policy governed by these Special Conditions shall terminate with respect to the particular insured if any of the following conditions occurs:

a) after the insurance company's **claim payment** under these Special Conditions, or

b) if the insured **becomes eligible for retirement (old-age) pension,** or

c) if the insured **reaches** the **retirement age** applicable to him/her.

If any one of the conditions listed in subsections b) and c) of this clause occurs, the **insured is required to communicate it in writing to the insurance company within 15 days after the condition has occurred.**

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Partial Disability Insurance (exceeding 39%) (KEOEP/22017)

These Special Conditions set out the standard terms and conditions for the **partial (exceeding 39%) disability insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

For the purposes of these policy conditions, the term 'National Institute of Medical Experts' means any official body authorized under effective legislation to determine a degree of disability (physical or mental impairment).

I. INSURED

Pursuant to these Special Conditions, the insurance policy **is not available** to natural persons, who – **prior to the conclusion of the insurance policy (signing the insurance application)**

a) have been granted **pension benefits on their own right, or any other benefit/allowance** (e.g.: disability, accident) for physical or mental impairment or impaired earning capacity pursuant to the expert opinion of the National Institute of Medical Experts, or
b) **have already applied for** the determination or review of the extent of a permanent impairment (disability) or loss of earning capacity with the **competent authority.**

II. INSURED EVENT

II.1. The insured event is a sudden, unexpected development of an **illness** without precedent conditions prior to the commencement of the insurance coverage, or an **accident** during the coverage period, **as a result of which the National Institute of Medical Experts determines in its expert's opinion that the insured has suffered permanent impairment to an extent exceeding 39 percent and does not recommend the insured's rehabilitation,** provided that **the insured submits the application for the determination of the permanent disability while the insurance policy is in force.**

II.2. The **date** of the insured event is the **issue date of the expert's opinion of the National Institute of Medical Experts.**

II.3. If the execution date of expert's opinion of the National Institute of Medical Experts is a later date than the cancellation date of the insurance, the insurance company shall only make a payout if the application for the verification of the insured's permanent disability has been submitted to the competent authority prior to the termination of the insurance.

III. INSURANCE BENEFITS AND COVERED SERVICES

III.1. If an insured event occurs, the insurance company shall pay the **sum insured stated in the certificate of coverage** in force as at the date when the professional opinion of the National Board of Medical Experts is issued, and at the same time the insurance cover under these Special Conditions shall terminate with respect to the particular insured.

If the execution date of expert's opinion of the National Institute of Medical Experts is a later date than the termination of the insurance, the insurance company will determine the benefit payout on the basis of the **sum insured stated in the most current effective certificate of coverage.**

III.2. **If an insured event occurs, the insurance company is entitled to charge the insurance premium calculated for the insured concerned until the end of the policy year in which the insured event occurred.**

III.3. If the insurance policy has been taken out with a waiting period (Clause II.3.5. of the General Conditions) and the insured is diagnosed with **an illness which is not in any way caused by an accident** before the end of such waiting period and such illness leads to the insured's permanent impairment to an extent exceeding 39 percent, the insurance company shall **refund to the policyholder all insurance premiums paid for the insurance coverage** subject to these Special Conditions with respect to the particular insured.

Once the premium is refunded, the insurance coverage governed by these Special Conditions shall terminate with respect to the particular insured **retroactively** to the commencement of this risk coverage.

III.4. If the insurance policy has been taken out with a waiting period (Clause II.3.5. of the General Conditions) and the insured **applies for** the verification of his/her impairment at the competent authority **during such waiting period,** the insurance company shall refund to the policyholder all insurance premiums paid for the insurance coverage subject to these Special Conditions with respect to the particular insured, save for the case if the ground for the claim is a result of a documented accident which occurred after the inception date of the insurance coverage.

Once the premium is refunded, the insurance coverage governed by these Special Conditions shall **terminate** with respect to the particular insured **retroactively** to the commencement of this risk coverage.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

IV.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

IV.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

IV.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

IV.3.2. **and a copy of the following documents:**

a) **The expert opinion of the National Institute of Medical Experts,**
b) if the expert's opinion of the National Institute of Medical Experts is issued after the insurance is terminated, the document evidencing the date when the application for the determination of the insured's permanent impairment of a degree exceeding 39 percent was submitted,
c) a certification from the treating physician or the general practitioner describing the primary medical cause(s) of the insured event, as well as the exact date of the first diagnosis and the progression of the illness,
d) if the permanent impairment of an extent of more than 39 percent is **directly arising from the accident,** then
   – all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
   – the accident & injury report, or the workplace accident & injury report, if available,
e) **in the case of a road traffic accident,** in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a motor vehicle,** the driver's license and the vehicle registration certificate.

IV.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV.5. **The insurance company is entitled to have the insured's medical conditions reviewed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

IV.6. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

V. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for benefits specified in these Special Conditions in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

VI. TERMINATION OF INSURANCE SUBJECT TO THESE CONDITIONS

The insurance coverage under a policy governed by these Special Conditions shall terminate with respect to the particular insured if any of the following conditions occurs:

a) after the insurance company's **claim payment** under these Special Conditions, or
b) if the insured **becomes eligible for retirement (old-age) pension,** or
c) if the insured **reaches the retirement age** applicable to him/her.

If any one of the conditions listed in subsections b) and c) of this clause occurs, the **insured is required to communicate it in writing to the insurance company within 15 days after the condition has occurred.**

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of 40 Critical Illnesses Insurance (KEDRD//02017)

These Special Conditions set out the standard terms and conditions for the **critical illness cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. THE INSURED EVENT, THE DATE OF THE INSURED EVENT

I.1. The insured event is a sudden, unexpected onset of any one of the illnesses listed below and defined in Clause I.2, any time during the coverage period, without precedent conditions prior to the commencement of the insurance coverage, as well as the medical treatment or surgery required to treat a sudden primary disease with no pre-existing symptoms relative to the commencement of the insurance coverage.

1) myocardial infarction (heart attack)
2) malignant tumors,
3) cerebrovascular accident
4) chronic renal failure,
5) coronary artery surgery,
6) organ transplantation,
7) AIDS
8) benign tumors
9) pacemaker-defibrillator implant surgery
10) atherosclerosis heart disease (coronaria sclerosis)
11) coronary bypass surgery
12) heart valve surgery
13) cardiomyopathy
14) cerebral venous surgery
15) open thoracic and/or abdominal aorta repair
16) aortobifemoral bypass surgery
17) Alzheimer's disease (AD)
18) Parkinson's disease (PD)
19) multiple sclerosis (MS)
20) loss of hearing
21) loss of vision
22) loss of speech
23) aplastic anaemia
24) haemophilia
25) Osler disease
26) hepatitis C virus infection
27) severe burn
28) ulcerative colitis
29) familial adenomatous polyposis (FAP)
30) Crohn's disease
31) small bowel surgery
32) nephrostomy surgery
33) terminal state pulmonary disease
34) rheumatoid arthritis (RA)
35) ankylosing spondylitis (Bekhterev's disease)
36) amputation
37) facial nerve paralysis
38) esophageal stricture
39) constrictive pericarditis
40) chronic acquired skin inflammation

I.2. For the purposes of these Special Conditions, the **medical conditions listed in Clause I.1. shall have the following definitions:**

1) **Myocardial infarction** (heart attack) is the sudden loss of blood supply resulting in cell death in a certain part of the heart. For the purposes of these Special Conditions, only those pathological condition shall be regarded myocardial infarction, where the extent of the tissue damage results in pathological Q waves which may be visualized by standard ECG registration techniques.
The date of the insured event: the time of the onset of the illness, as established by the attending physician.

2) In the case of **malignant tumors** a group of cells with signs of abnormality (malignant neoplasm) display uncontrolled growth, and this abnormal mass of malignant tissue grows beyond the normal limits, intruding on and destroying adjacent tissues (invasion), and sometimes spread to and invade other locations in the body (metastasis) where they start to multiply.
For the purposes of these Special Conditions, malignant tumors include: hematological malignancies (leukemia), tumors developing from the reticuloendothelial system and the lymphatic system (lymphoma), and the cancer of plasma cells (multiple myeloma).
The insurance does not cover the following groups of malignant tumors:
– premalignant (pre-carcinoma) conditions,
– non-invasive (in situ) tumors,
– skin cancer, except malignant tumors of melanocytes (malignant melanoma),
– any tumor that develops following a diagnosis of HIV.
The date of the insured event: the date of the diagnosis of the disease.

3) **Cerebrovascular accident:** a rapidly developing loss of brain function(s) due to disturbance in the blood supply to the brain (ischemia caused by partial or full blockage [thrombosis, arterial embolism], or a hemorrhage [leakage of blood]), as a result of which the affected area of the central nervous system dies leading to permanent neurological damage (plexus injuries), i.e. the physical symptoms indicative of the damage are present even after 30 days after the stroke. **The insurance does not cover a cerebrovascular accident where there is a causal link to an accident** within the meaning of Clauses IX.1. and IX.2. of the General Conditions.
The diagnosis of the **cerebrovascular accident,** the permanent neurological deficit and the causal link between the two shall be **determined by the medical expert of the insurance company, or a specialist named by the medical expert.**
The date of the insured event: the date determined as the onset of the illness, provided that the physical symptoms indicative of the permanent damage to the nervous system are present even after 30 days following the onset of the illness.

4) **Chronic renal failure:** an irreversible worsening of renal function in both kidneys, where the extent of the worsening is so large that it results in a condition that is incompatible with life without renal replacement therapy in a form of dialysis, or a kidney transplant, and the insured needs to receive renal dialysis for at least 60 days.
The date of the insured event: the first day of the renal dialysis, provided that the insured needs to receive dialysis for at least 60 days.

5) **Coronary artery surgery:** an open surgical procedure performed to treat a narrowing or a blockage of two or more coronary arteries confirmed by coronarography by removing the damaged arteries and replacing them with healthy arteries from elsewhere in the patient's body or by bypassing it with healthy arteries.
The date of the insured event: the date of the surgery.

6) **Organ transplantation:** the surgical moving of a heart, a heartlung complex, lungs, a liver or a kidney from one body (donor) to another (recipient). **Human cell and tissue transplantation shall not be understood as organ transplantation. Therefore, the insurance does not cover the transplantation of pancreas, skin and bone, or blood transfusion.**
The date of the insured event: the date of the surgery.

7) **AIDS** is a medical condition, where the CD4+ cell (lymphocyte) count in the blood of the person infected by HIV is permanently under 200/µl, and an illness is caused by an opportunistic infection – an infection by pathogens that are normally present and do not cause illness in a healthy host.
The date of the insured event: the date of the diagnosis of the disease.

8) **Benign tumors** mean a cerebral or spinal chord tumor demonstrated as benign by a developed diagnostic method (CT/MR), which results in the total paralysis of one half of the body even after 6 months of treatment completion.
The date of the insured event: the date of the diagnostic procedure confirming the disease.

9) **Pacemaker-defibrillator implant surgery** means final pacemaker and defibrillator implant surgery required by reason of an impulse conduction disorder and ventricular fibrillation.
The date of the insured event: the date of final pacemaker and defibrillator implant surgery.

10) **Atherosclerosis heart disease (coronaria sclerosis)** means a coronary stenosis affecting three vessels to a degree certified to require revascularization by a cardiac catheter procedure, however, the main coronary supplying the left ventricle of the heart (LAD) is not suitable for any intervention and surgery based on medical documentation.
The date of the insured event: the date of the cardiac catheterization.

11) **Coronary bypass surgery** means an open thoracic coronary surgery in the course of which all three main coronary vessels have been simultaneously bypassed by a surgical procedure, and following surgery, at least 50% stenosis is arrested in the main coronary branch supplying the left ventricle of the heart (LAD), and such stenosis, remaining after the surgery, is verified by a cardiac catheter test performed at least 6 months after date of the surgery; and based on the documentation of a special cardiology test performed at least 30 after such cardiac catheter test, no better result than 50% stenosis can be achieved even by further intervention.
The date of the insured event: the date of the surgery.

12) **Heart valve surgery** means an open thoracic heart surgery involving extracorporal ("heart motor") circulatory maintenance, in the course of which valve plastic surgery and / or valve exchange are performed, following which the insured is subject to cardiology control even after the 30th day following such surgery.
The date of the insured event: the date of the surgery.

13) **Cardiomyopathy** means a myocardial disease in the course of which cardiac output (EF) fails to exceed 20% on an ongoing basis for at least 6 months, not even with permanent treatment.
The insurance does not cover cardiomyopathy if it is developed due to alcohol and drug consumption.
The date of the insured event: the date of the diagnosis of the disease.

14) **Cerebral venous** surgery means the surgery of a cerebral or tentorial vessel involving the opening of the neurocranium due to an illness. The insurance does not cover the surgery if it is required by reason of an accident or for the sole purpose of cranial cavity pressure reduction.
The date of the insured event: the date of the surgery.

15) **Open thoracic and/or abdominal aorta repair** means a surgery involving the opening of the thoracic and/or abdominal cavity due to an illness. The insurance does not cover the surgery if it is required by reason of an accident.
The date of the insured event: the date of the surgery.

16) **Aortobifemoral bypass surgery** means a bypass surgery performed on both femoral arteries due to vasoconstriction in the course of a single intervention.
The insurance does not cover the surgery if it is performed due to femoral vasoconstriction caused by arteriosclerosis diagnosed within 6 months of the commencement of coverage, or an intervention performed by vascular catheter technology.
The date of the insured event: the date of the surgery.

17) **Alzheimer's disease (AD)** means a neurological disease of a degree of severity characterized by a gradual deterioration of mental abilities, behavioral disorders, and biological degradation following dementia, the severity of which is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 49% of permanent impairment arising only from this illness.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

18) **Parkinson's disease (PD)** means a progressive neurological disease characterized by involuntary movements including shaking, rigidity, slowness of movement and dysequilibrium; and the severity of which is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 49% of permanent impairment arising only from this illness.
The insurance does not cover a disease diagnosed as Parkinson's syndrome (caused by e.g. medication, toxic injuiries, or arteriosclerosis).
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

19) **Multiple sclerosis (MS)** is a demyelinating progressive disease causing neurological and psychic symptoms, the severity of which is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 49% of permanent impairment arising only from this illness.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

20) **Loss of hearing** means an at least 91 Db hearing impairment on both ears as a consequence of an illness or accident, which is final and cannot be corrected by surgery or aid, and is sustained continuously for at least 6 months.
The date of the insured event: the date of the medical specialist examination document of otorhinolaryngology establishing loss of hearing on both sides, considering their status as final, and recording audiogram test results as well.

21) **Vision loss** occurs when the vision of both eyes has been impaired irreversibly for at least 6 months to such a degree, as a consequence of an illness or accident, with no correction possible for improvement, that the remaining field of vision fails to reach 10% on either eye due to scotoma, and /or only hand movements are perceived by both eyes due to the deterioration of visual acuity, or, as a joint consequence of scotoma and deterioration of visual acuity, the impairment of visual acuity is 100 %, the above being supported by the expert opinion of the National Institute of Medical Experts.
The date of the insured event: the date of the medical specialist examination document of ophthalmology supporting the insured event and describing the state as final.

22) **Loss of speech** occurs when the earlier sound speaking ability is impaired completely and finally to such a degree for at least 6 months, and cannot be corrected by applying any aid, that no intelligible words can be uttered due to a lack of sound volume and speech articulation as required for communication, and it is supported by the expert opinion of the National Institute of Medical Experts as well.
The insurance does not cover the loss of speech if it develops due to a psychiatric reason.
The date of the insured event: the issue date of the expert opinion of the National Institute of Medical Experts.

23) **Aplastic anaemia** occurs when the illness is supported by an expert opinion of haematology based on a bone marrow examination, and at least 4 units of transfusion (blood substitute) have been administered each month for at least 1 year. Blood preparations administered by reason of other illnesses or accidents are not included.
The date of the insured event: the date of the first transfusion as specified in the definition of the insured event.

24) **Haemophilia** occurs when continuous factor substitution has been required due to haemophilia for at least 1 year, and the missing blood clotting factor is below 1% of the physiological value.
The insurance does not cover factor substitution if it is required by reason of any intervention/surgery or any other illness involving a hazard of bleeding or if it is administered on a non-continuous basis.
The date of the insured event: the date of the first factor substitution as specified in the definition of the insured event.

25) **Osler disease** occurs when the illness is supported by expert opinions following medical specialist examination, and due to this disease, at least 4 units of transfusion (blood substitute) on average have been administered each month for at least 1 year. Blood preparations administered by reason of other illnesses or accidents are not included.
The date of the insured event: the date of the first transfusion as specified in the conditions of the insured event.

26) **Hepatitis C virus** infection is deemed to be an insured event if, after completion of antiviral or other therapeutic treatment, the treating hepatology institution documentation certifies the continued presence of hepatitis C virus infection and hepatic cirrhosis due to liver injury, associated with oesophageal varicosity and pathological liver function results, and no further causal treatment can be performed.
The date of the insured event: the date of the medical specialist examination document of hepatology supporting the insured event.

27) **Severe burns** means third-degree burns affecting at least 20% of the body surface area as a result of heat, and the insured requires medical treatment for more than 30 days after the date of such burn injuries.
The date of the insured event: the date of the accident.

28) **Ulcerative colitis** is deemed to be an insured event if the entire colon is removed due to an illness and a final ileostoma is prepared simultaneously.
The date of the insured event: the date of the surgery.

29) **Familial adenomatous polyposis (FAP)** is covered under this insurance if the entire colon is removed due to the illness and a permanent ileostoma is prepared simultaneously.
The date of the insured event: the date of the surgery.

30) **Crohn's disease** is covered under this insurance if intestinal sections have been removed 3 times during the course of the disease or a permanent stoma has been prepared (with the anus closed and the rectum removed).
The date of the insured event: the date of the 3rd surgery/of final stoma preparation.

31) **Small bowel surgery** is covered under this insurance if at least half of the small intestine has been removed for any reason, as evidenced by the operative report and histology records.
The date of the insured event: the date of the surgery.

32) **Nephrostomy surgery** is covered under this insurance if a permanent nephrostoma was prepared on both sides at least 6 months ago.
The date of the insured event: the date of the second or simultaneous bilateral nephrostoma preparation.

33) **Terminal state pulmonary disease** is covered under this insurance if the severity thereof is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 79% of permanent impairment arising only from this illness.
The date of the insured event: the issue date of the expert opinion of the National Institute of Medical Experts.

34) **Rheumatoid arthritis (RA)** is an insured event if the severity thereof is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 69% of permanent impairment arising only from this illness.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

35) **Ankylosing spondylitis (Bekhterev's disease)** is covered under this insurance if the severity thereof is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 69% of permanent impairment arising only from this spine disease.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

36) **Amputation** means the amputation of two or more limbs during the policy period for any reason excluding self-mutilation, to at least the upper third of the thigh in case of the lower limb, or above the wrist joint in case of the upper limb.
The date of the insured event: the date of the second or simultaneous amputation affecting two limbs.

37) **Facial nerve paralysis** occurs when Nervus facialis (facial nerve) is paralyzed to such a degree that nutrition is made impossible due to a mouth closure disorder, and the intake of food is ensured by implanted tube feeding through the abdominal wall to the stomach or the small intestine for at least 6 continuous months.
The date of the insured event: the date of implantation of the stomach or small bowel tube.

38) **Esophageal stricture** occurs when the esophagus is constricted to such a degree due to a disease of non-tumorous origin that the intake of food is ensured by surgically implanted tube feeding through the abdominal wall to the stomach or the small intestine for at least 6 continuous months.
The date of the insured event: the date of implantation of the stomach or small bowel tube.

39) **Constrictive pericarditis** is covered under this insurance if open thoracic pericardial surgery has been performed for treatment.
The date of the insured event: the date of the surgery.

40) **Chronic acquired skin inflammation** (e.g. allergic or irritative contact skin inflammation, atopic dermatitis, psoriasis) is deemed to be an insured event if such inflammation – in spite of treatment directed by a dermatologist – has been continuously affecting, in an active state, at least 50% of the surface of the body, both palms and both soles for at least one year at the time of the notification of the claim for benefit.
The date of the insured event: the date of the diagnosis of the disease.

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If an insured event occurs, **the insurance company will pay the sum insured specified on the certificate of coverage** effective as at the date of the insured event, **and at the same time the critical illness coverage of the insurance policy will terminate.**

II.2. If **the insurance benefit** defined in Clause II.1. of these Special Conditions is not claimed and paid out **while the insured is alive, and in the opinion of the insurer's medical expert, the insured event resulted from any of the illnesses listed in Clause I.1. of these Special Conditions,** the insurance company will **pay to the beneficiary** the **death sum insured stated on the certificate of coverage** effective at the date of the insured's death.

II.3. Pursuant to these Special Conditions, the **insurance pays out the sum insured as an insurance benefit only once** with respect to the same insured, even if the insured has **more than one of the illnesses** listed under Clause I.1. of these Special Conditions **at the same time or one after another.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **The following documents must be attached to the notice of claim:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**
a) the hospital discharge summary,
b) if a surgery was performed, the operative report, if available.

III.3.3. **as well as the documents specified below:**

1) on myocardial infarction
a) ECG changes indicating a recent myocardial infarction (for the purposes of these Special Conditions, myocardial infarction is only covered if it develops from a blockage of the coronary artery, and the interval of a previously undetected pathological Q-wave in any of the leads of a traditional – 12 lead – ECG graph exceeds 40 ms, and its amplitude exceeds 25% of the amplitude of the R wave), and
b) elevation of cardiac enzymes above the generally accepted laboratory levels of normal – that is: documented and significant elevation of any intracellular enzyme (CPK, CKMB, SGOT, LDH, alfa-HBDH) above the generally accepted laboratory levels of normal shall fulfill this condition.

2) on a malignant tumor
a copy of the positive histological confirmation (describing the malignant nature of cells and their invasive growth).

3) on a cerebrovascular accident
a copy of the medical documents confirming the permanent neurological deficit with clinical symptoms persisting even 30 days after the cerebrovascular accident evidenced in an official document.

4) on chronic renal failure a copy of the medical documents in proof of the regular dialysis of the insured for at least 60 days, issued by the medical facility that performs the dialysis.

5) on a coronary artery surgery
a copy of the hospital discharge summary confirming that a bypass surgery was performed pursuant to an appropriate medical opinion based on deviations of a preliminary coronarography.

6) on an organ transplantation
a copy of the medical document in proof of the surgical procedure that has been performed in accordance with an appropriate medical advice.

7) on AIDS
a) at least two test results which prove that the CD4+ cell count is under the critical level and
b) the document in proof of a relating opportunistic infection.

8) **on a benign tumor**
   a) the document of the diagnostic procedure diagnosing the disease,
   b) the results of the neurosurgery or neurology control check to support the insured event, performed at least 6 months after treatment is completed.
9) **on a pacemaker-defibrillator implant surgery** all documents produced in relation to the cardiovascular disease,
10) **on an atherosclerosis heart disease (coronaria sclerosis)**
   a) all documents produced in relation to the cardiovascular disease,
   b) documentation of cardiac catheterization.
11) **on a coronary bypass surgery**
   a) all documents produced in relation to the cardiovascular disease,
   b) results of cardiac catheterization performed at least 6 months after the surgery, and
   c) results of the cariology control check performed at least 30 days after cardiac catheterization.
12) **on a heart valve surgery**
   a) all documents produced in relation to the cardiovascular disease,
   b) the hospital discharge summary evidencing the open thoracic surgery,
   c) results of the cariology control check performed at least 30 days after the surgery.
13) **on cardiomyopathy**
   the complete documentation of the cardiological workup, including documents on the 6 months preceding the submission of the notice of claim.
14) **on a cerebral venous surgery**
   all medical documents produced in relation to the illness which required the undergoing of surgery.
15) **on an open thoracic and/or abdominal aorta repair**
   all medical documents produced in relation to the illness which required the undergoing of surgery.
16) **on an aortobifemoral bypass surgery**
   all medical documents produced in relation to the illness which required the undergoing of surgery.
17) **on Alzheimer's disease (AD)**
   a) all medical documents produced in relation to the illness
   b) the expert opinion of the National Institute of Medical Experts
18) **on Parkinson's disease (PD)**
   a) all medical documents produced in relation to the illness
   b) the expert opinion of the National Institute of Medical Experts
19) **on Multiple sclerosis (MS)**
   a) all medical documents produced in relation to the illness
   b) the expert opinion of the National Institute of Medical Experts
20) **on total hearing loss**
   a) all medical documents produced in relation to the loss of hearing,
   b) the audiograms evidencing the occurrence of the insured event.
21) **on total vision loss**
   a) all medical documents produced from the commencement of visual deterioration to the submission of the notice of claim,
   b) the expert opinion of the National Institute of Medical Experts
22) **on the loss of speech**
   a) all medical documents produced from the loss of speech to the submission of the notice of claim,
   b) the expert opinion of the National Institute of Medical Experts
23) **on aplastic anaemia**
   all medical documents produced in relation to the illness, including documentation on transfusions.
24) **on haemophilia**
   all medical documents produced in relation to the illness, including documentation on factor supplementation.
25) **on Osler disease**
   all medical documents produced in relation to the illness, including documentation on transfusions.
26) **on Hepatitis C virus infection**
   all medical documents produced in relation to the illness.
27) **on severe burns**
   all medical documents produced in relation with the accident, including any medical documents on treatment from the date of the accident to any date beyond the 30th day after the date of the accident.
28) **on ulcerative colitis**
   a) all medical documents produced in relation to the illness.
   b) the surgery discharge summary with the operative report.
29) **on familial adenomatous polyposis (FAP)**
   a) all medical documents produced in relation to the illness
   b) the surgery discharge summary with the operative report.
30) **on Crohn's disease**
   a) all medical documents produced in relation to the illness
   b) the surgery discharge summary with the operative report.
31) **on small bowel surgery**
   a) all medical documents produced in relation to the illness
   b) the surgery discharge summary with the operative report as well as the histological test results.
32) **on nephrostomy surgery**
   a) all medical documents produced in relation to the illness, including the results of the urology control check performed at least 6 months of the surgery,
   b) the surgery discharge summary with the operative report.
33) **on terminal state pulmonary disease**
   a) all medical documents produced in relation to the illness
   b) the expert opinion of the National Institute of Medical Experts
34) **on rheumatoid arthritis (RA)**
   a) all medical documents produced in relation to the illness
   b) the expert opinion of the National Institute of Medical Experts

35) on ankylosing spondylitis (Bekhterev's disease)
a) all medical documents produced in relation to the illness
b) the expert opinion of the National Institute of Medical Experts

36) on amputation
hospital discharge summary/summaries and operative report/s in relation to the amputations.

37) on facial nerve paralysis
all medical documents produced in relation to the illness, including the results of the control check performed at least 6 months of surgery.

38) on esophageal stricture
all medical documents produced in relation to the illness, including the results of the control check performed at least 6 months of surgery.

39) On constrictive pericarditis
all medical documents produced in relation to the illness, including documentation on the cardiology examination preceding the surgery.

40) on chronic acquired skin inflammation
all medical documents produced from the date of diagnosis of the disease to the notification of the claim for benefit, including medical documents of treatments directed by a dermatologist authorized to treat the disease.

III.11. **In the event of death resulting from any of the insured events included in these Special Conditions, a copy of the following documents shall also be submitted:**
a) cause of death medical certificate /hospital course summary,
b) the insured's certificate of death,
c) the medical documents in proof of the date of the first diagnosis and describing the progression of the illness which led to the insured's death or the **primary disease requiring surgery,** as well as any other documents required for clarification of the circumstances of the death (physician's certification, hospital discharge summary, pathology report, etc.),
d) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

III.12. In addition to the above, the insurance company may request or obtain additional certifications or statements – listed in Clause V.3.3 of the General Conditions – for the settlement of the claim.

III.13. The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.

III.14. The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

IV.1. In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for a critical illness benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

IV.2. For the purposes of these Special Conditions, notwithstanding the provisions set forth in Clause VII.1.1. c) of the General Conditions, the insurance covers HIV infection, save for the case if the insured had already been infected by HIV at the time when the insurance application was submitted.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Incapacity Insurance (KEKEK/02017)

These Special Conditions set out the standard terms and conditions for the **incapacity insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. ELIGIBILITY CONDITIONS FOR INCAPACITY INSURANCE

I.1. Pursuant to these Special Conditions, no natural person **without eligibility to Statutory Sick Pay (SSP)** under the national health insurance scheme may be covered under this incapacity insurance.

I.2. The **policyholder/insured is required to notify** the insurance company **within 15 days** if the **eligibility to a statutory sick pay** under the national health insurance scheme **terminates during the policy period.** In such a case the accident-related incapacity insurance coverage of the particular insured shall terminate on the first day of the month following the date when the insured's eligibility for sickness benefit is terminated.

I.3. If the Incapacity Insurance cover of a policy is terminated with respect to a particular insured in accordance with Clause I.2., the cover may be reinstated pursuant to a written request by the policyholder and the insured, with the insurance company's permission when the cause of the termination no longer exists, and after the insurance company completed the underwriting procedure.

II. INSURED EVENT

II.1. The insured event is the **illness or accident** (within the meaning of Clauses IX.01. and IX.2. of the General Conditions) which occurs during the coverage period and **as a result of which the insured becomes incapacitated in his/her own right and is granted a statutory sick pay in accordance with effective legislation,** and the incapacity is certified by an approved physician who is authorized to assess and certify the incapacity status.

II.2. If the insured is incapacitated **because of an accident,** the date of the insured event is the **date of the accident;** if the insured is incapacitated **because of illness,** the date of the insured event is the **first day of the incapacity period.**

III. INSURANCE BENEFITS AND COVERED SERVICES

III.1. **In the event of the insured's illness,** the insurance covers the **insured's incapacity period during the coverage period,** while **in the event of an accident of the insured,** the insurance covers the **insured's incapacity period needed to recover from the medical consequences of such accident** which may arise within two years after the date of the insured's accident, subject to the provisions of Clauses III.2. and III.3. of these conditions.

III.2. **The insurance does not pay a benefit for the first day of the continuous period of incapacity and for the number of days specified in the policy (or the insurance application) (hereinafter: elimination period).**

III.3. **Once the elimination period is over,** the insurance company will **pay out the sum insured specified in the certificate of coverage current as of the particular day for all additional days.**

If the insured is **incapacitated** (partially or fully) **as a result of an accident** after the coverage period ended, the benefit payout shall be determined on the basis of the **sum insured stated in the most current effective certificate of coverage.**

III.4. If the insurance anniversary falls within a period when the insured is certifiably incapacitated, and the **insurance policy is taken out with annual indexation** (Clause IV.7. of the General Conditions), the insurance company shall **pay an increased benefit** in accordance with the rules of annual indexation, **after the insurance anniversary.**

III.5. **If a claim is grounded, the insurance company will make a benefit payment for no more than 90 days of incapacity due to illness within any one policy year, and for no more than 150 days of incapacity due to an accident and in relation to the same accident within two years after the date of the accident.**

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

IV.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

IV.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2 of the General Conditions governing the insurance policy:**

IV.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

IV.3.2. **and a copy of the following documents:**

a) the standard medical certificate of incapacity issued by a physician who is authorized to confirm and certify incapacity pursuant to effective legislation (Medical Certificate of Incapacity (Pregnancy)),

b) if hospital care was received: the hospital discharge summary, within 15 days after the end of the hospital treatment,

c) additionally, if the insured event is the **direct result of an accident:**
   – all medical documents produced in connection with the insured event from the occurrence of the accident until filing the insurance claim, in particular the medical documentation of the first medical treatment,
   – the accident & injury report, if available,
   – the result of the blood alcohol and/or drug test, if available,
d) in the case of a road traffic accident, in addition to the above:
   – the police report, if available,
   – if the insured **was injured** in a road traffic accident as the **driver of a vehicle,** a copy of the driver's license and the vehicle registration certificate.

IV.4. **in any continuing period of incapacity:**
a) the documents listed in Clauses IV.3.1 and IV.3.2. c) and d), are required to be submitted only with the first notice of claim,
b) a copy of the medical certificate on the insured's continuing period of incapacity issued by a health care provider authorized to assess incapacity pursuant to effective legislation, shall be submitted to the insurance company within 14 days after it is issued, with reference to the policy number (hereinafter: medical certificate on a continuing period of incapacity);
c) new medical documents produced on the insured's medical conditions shall be submitted to the insurance company by the insured at least once in every 60 days.

IV.5. The insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV.6. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

IV.7. **The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

V. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

V.1. In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a claim for incapacity benefit in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

V.2. In addition to the exclusions set forth in the General Conditions, the insurance coverage shall not apply to the insured's incapacity if during such incapacity period the insured pursues gainful activities.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Term Life Insurance with Death Benefit (KÉHAT/02017)

These Special Conditions set out the standard terms and conditions for the **term life insurance cover with death benefit available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is the **insured's death during the coverage period.**

I.2. The date of the insured event is the **date of the death.**

II. INSURANCE BENEFITS AND COVERED SERVICES

If an insured event occurs, the insurance company shall pay out the **sum insured stated in the certificate of coverage effective at the time when the insured dies,** provided that the claim is grounded.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to those set out in Clause V.3.2. of the General Conditions governing the insurance policy:**

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**

a) cause of death medical certificate / hospital course summary,
b) the autopsy report, if available,
c) the insured's certificate of death,
d) if the death is **the result of an illness:**
   – documents in proof of the date and progression of the illness which led to the insured's death, and any other documents required for the clarification of the circumstances of the death (physician's certification, hospital discharge summary etc.),
e) if the death is **the result of an accident:**
   – all medical documents produced in connection with the insured event from the occurrence of the accident until the notice of claim is submitted, in particular the medical documentation of the first medical treatment,
   – the accident & injury report, the police report, if available,
   – the result of the blood alcohol and/or drug test, if available,
f) **in the case of a road traffic accident,** in addition to the above:
   if the insured **was injured or died** in a road traffic accident **as the driver of a motor vehicle,** a copy of the driver's license and the vehicle registration certificate,
g) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance), provided that the beneficiary was not named in the insurance policy.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3. of the General Conditions –** for the settlement of the claim.

IV. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a death claim in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Term Life Insurance with Survivor Benefit (KÉHAT/12017)

These Special Conditions set out the standard terms and conditions for the **term life insurance cover with survivor benefit available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. DEFINITION OF CO-INSURED

Under policies concluded pursuant and subject to these Special Conditions, the insured's **spouse,** or failing that, the insured's **domestic partner living in the same household for at least one year shall also be insured** (hereinafter: co-insured).

II. INSURED EVENT

II.1. Under the present policy, the insurance coverage shall apply to the **death of the co-insured during the coverage period.**

II.2. The date of the insured event is the **date of the death.**

III. INSURANCE BENEFITS AND COVERED SERVICES

If an insured event occurs, the insurance company shall pay **the sum insured specified on the certificate of coverage effective** as of the date of the insured event, as the death benefit **for the heir/heirs of the co-insured.** If an insured event occurs, the insurance coverage pertaining to the co-insured will terminate.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

IV.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

IV.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to** those set out in Clause V.3.2 of the General Conditions governing the insurance policy:

IV.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

IV.3.2. **and a copy of the following documents:**

a) cause of death medical certificate / hospital course summary,
b) autopsy report,
c) the certificate of death,
d) if the death is **the result of an illness:**
   – documents in proof of the date and progression of the illness which led to the insured's death, and any other documents required for the clarification of the circumstances of the death (physician's medical statement, hospital discharge summary etc.),
e) if the death is **the result of an accident:**
   – all medical documents produced in connection with the insured event from the occurrence of the accident until filing the insurance claim, in particular the medical documentation of the first medical treatment,
   – the accident & injury / police report, if available,
   – the result of the blood alcohol and/or drug test, if available,
f) in the case of a road traffic accident, in addition to the above: if the co-insured **was injured or died in a road traffic accident as the driver of a motor vehicle,** the driver's license and the vehicle registration certificate;
g) **a copy of the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance), provided that the beneficiary was not named in the insurance policy,
h) in a marriage, the marriage certificate,
i) in a civil partnership, a statement verifying at least one year of cohabitation, signed by two witnesses.

IV.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.3 of the General Conditions –** for the settlement of the claim.

V. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT, EXCLUSIONS

In respect of claims arising from this insurance, the insurance company will be released from its obligation to pay a death claim in the cases listed in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

The effective date of these Special Conditions is: September 1, 2017

Special Conditions of Childbirth Allowance Insurance (KÉGYR/02017)

These Special Conditions set out the standard terms and conditions for the **childbirth allowance insurance cover available under group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these Special Conditions.

In the case of matters not regulated by these Special Conditions, the insurance **shall be governed by the General Terms and Conditions of Group Insurance Policies** (hereinafter: General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **the birth of a living child** by the insured **during the coverage period.**

I.2. The date of the insured event is the **date of the child's birth.**

II. INSURANCE BENEFITS AND COVERED SERVICES

II.1. If an insured event occurs, the insurance company shall pay **the sum insured specified on the certificate of coverage effective** as of the date of the insured event.

II.2. **If twins or multiples are born, the sum insured payable as the insurance benefit shall be multiplied by the number of children born.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. A notice of claim **must be submitted** to the insurance company **in writing within 15 days** after the occurrence of the insured event.

III.2. Where the **above time limit is not respected** and as a result material conditions or circumstances cannot be revealed, the **insurance company may be released from its obligation to pay the claim.**

III.3. **When the notice of claim is submitted, the following documents shall also be attached in addition to** those set out in Clause V.3.2 of the General Conditions governing the insurance policy:

III.3.1. a **duly completed standard insurance claim form** supplied by the insurance company,

III.3.2. **and a copy of the following documents:**
a) the birth certificate of the child (children),
b) the hospital discharge summary.

IV. EVENTS EXCLUDED FROM THE INSURANCE COVERAGE

IV.1. The insurance does not cover the cases set out in Clause VII.3 of the General Conditions governing the insurance policy.

IV.2. An insured event arising from a pregnancy that occurred before the insurance application was completed will not be grounds for a claim for benefit.

The effective date of these Special Conditions is: September 1, 2017