General and Special Conditions of PAJZS Employer's Group Insurance (KMÁSF/02026)

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Contents

General Terms and Conditions of PAJZS Employer's Group Insurance (KMÁSF/02026) 3

I. Subject of the insurance policy 3
II. General provisions 3
III. Rights and obligations of the parties to the insurance policy 5
IV. Insurance Premium 6
V. Insured events, insurance benefits and conditions for payment by the insurance company 8
VI. Exemption of the insurance company from benefit payment 9
VII. Events excluded from insurance cover 10
VIII. Miscellaneous provisions 11
IX. Terms and Definitions 11
X. Provisions of the General Conditions Materially Deviating from the Hungarian Civil Code 12

Annex "A" – Permanent health impairment 14

Annex "B" – Classification of surgical groups by surgical benefit categories 15

Annex "C" – Extreme sports risks 16

Annex "D" – Hazardous occupations 17

Special conditions of insurance cover for accident-related death (KBHAT/02026) 18

Special conditions of insurance cover for accident-related permanent health impairment with linear benefit (KBROK/02026) 19

Special conditions of insurance cover for accident-related permanent health impairment with progressive benefit (KBROK/12026) 21

Special conditions of insurance cover for bone fracture (KBCST/02026) 23

Special conditions of insurance cover for injuries with a recovery period exceeding 14 or 28 days (KBSER/02026) 24

Special conditions of insurance cover for soft tissue injury (KBLSE/02026) 25

Special conditions of insurance cover for accident-related expense reimbursement and damage to baggage and clothing (KBKTS/02026) 27

Special conditions of insurance cover for accident-related daily hospital benefit (KBKNT/02026) 29

Special conditions of insurance cover for accident-related surgical benefit (KBMÜT/02026) 31

Special conditions of insurance cover for accident-related burn injury (KBÉGS/02026) 32

Special conditions of insurance cover for death caused by a traffic accident (KKHAT/02026) 34

Special conditions of insurance cover for traffic accident-related permanent health impairment (KKROK/02026) 35

Special conditions of insurance cover for accident-related incapacity for work (KBKEK/02026) 37

Special conditions of insurance cover for daily hospital benefit (KEKNT/02026) 39

Special conditions of insurance cover for surgical benefit (KEMÜT/02026) 41

Special conditions of insurance cover for health impairment exceeding 69% (KEOEP/12026) 43

Special conditions of insurance cover for health impairment exceeding 39% (KEOEP/22026) 45

Special conditions of insurance cover for 40 specified critical illnesses (KEDRD/02026) 47

Special conditions of insurance cover for incapacity for work (KEKEK/02026) 54

Special conditions of insurance cover for lump-sum incapacity-for-work benefit (KEKEK/12026) 56

Special conditions of term life insurance (KÉHAT/02026) 58

Special conditions of insurance cover for the death of a spouse (KÉHAT/12026) 59

Special conditions of insurance cover for childbirth benefit (KÉGYR/02026) 60

General Terms and Conditions of PAJZS Employer's Group Insurance (KMÁSF/02026)

These general conditions of Pajzs Employer's Group Insurance (hereinafter: general conditions), together with the special conditions, apply to the insurance policies of Generali Biztosító Zrt. (hereinafter: insurance company) that include life, accident and health insurance cover (hereinafter: policy), provided that the policy has been concluded by reference to these general conditions and the relevant special conditions.

The general conditions are supplemented by the **special conditions** for the life, accident and health insurance products containing the benefit selected by the policyholder in the insurance application.

In matters not regulated by these general conditions or by the special conditions (hereinafter together: policy conditions), the document titled 'Customer Information of Generali Biztosító Zrt. and General Provisions Governing Insurance Policies' (hereinafter: Customer Information), the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply.

The provisions of the special conditions may differ from those of the general conditions, 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. SUBJECT OF THE INSURANCE POLICY

Under the insurance policy, the insurance company undertakes to provide insurance cover for the risks specified in these general conditions and the special conditions, and to pay the insurance benefit if an insured event occurs, while the policyholder 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 premium, provides cover for the insured risks and undertakes the obligation to deliver insurance services (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 shall mean 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 in the insurance policy with respect to specific insured events. The insured persons are first named at the time of completing the application, but the policyholder may also initiate the extension of the cover to add new or additional insured persons after the policy has been concluded.

II.1.4. Several insured groups defined by name or by headcount may be created under a policy concluded on the basis of these general conditions. Each insured group may contain insured persons 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. Hazardous occupations are listed in Annex "D" to the general conditions, which forms part of the policy.

Insured groups may be created only on the basis of job, type of work, place of work or position in the organizational hierarchy. When submitting the insurance application, the policyholder shall clearly define the relevant insured group by specifying its job role, type of work, place of work or position within the organizational hierarchy and, where possible, shall also state the place where the activity is performed.

II.1.5. **Beneficiary** shall be any 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 the parties agree otherwise, by signing the insurance application the policyholder consents to the insured person(s) designating or changing a beneficiary in writing during the existence of their insurance cover in respect of the insured, without any separate declaration by the policyholder.**

II.1.6. Benefits due during the insured's lifetime are payable to the insured or to the person(s) designated in writing in the policy. If the insured dies, the beneficiary shall be the person(s) designated in writing in the policy or, in the absence of a beneficiary designation, the insured's heir(s).

II.1.7. **The designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.8. A beneficiary may be designated, and the beneficiary designation may be changed, in writing at any time when insurance cover in respect of the insured is established or during the period of insurance, before the insured event occurs.

II.2. Conclusion of the insurance policy and insurance cover in respect of the insured; amendment of the policy

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

II.2.2. For **insured groups defined by headcount** and **insured groups defined by name** that are not subject to medical underwriting (III.2.5.), insurance cover in respect of the insured shall come into effect without an insured's declaration.

II.2.3. For an **insured group defined by name and subject to medical underwriting** (III.2.5.), insurance cover in respect of the insured shall be validly established only if an insured's declaration is completed and the risk assessment procedure specified by the insurance company for medical underwriting is carried out.

II.2.4. The **insured's declaration** is a document which contains the insured person's consent to the extension of insurance cover to that insured person, information on the insured person's rights and obligations, including in particular the release of the relevant authorities and institutions from their duty of confidentiality, and, where applicable, the insured person's beneficiary designation.

The insured's declaration forms part of the insurance policy.

II.2.5. The insured must complete all declarations made by them truthfully and in full. The questions asked by the insurance company and the answers given to them form part of the policy.

II.2.6. The insured may withdraw their insured' declaration any time in writing. As a result of the withdrawal, the insurance cover in respect of the insured concerned shall terminate at 00:00 on the first day of the month following receipt by the insurance company of the withdrawal declaration. **The insured may not replace the policyholder in the insurance policy.**

II.2.7. Any premium or premium installment paid by the policyholder to the insurance company before the insurance policy is concluded shall qualify as an advance premium, which the insurance company shall hold without interest. If the policy is concluded, the insurance company shall credit the advance premium against the insurance premium. If the policy is not concluded, the insurance company refunds the advance premium to the policyholder.

II.2.8. The insurance company may carry out **underwriting** before accepting the insurance application or before extending or amending insurance cover in respect of the insured concerned, and may, for that purpose, require the insured to submit a medical history statement, undergo a medical examination and make other written declarations. The insurance company may request the medical history statement from the insured either on a paper form or by telephone at a pre-arranged time. Where the medical history statement is made by telephone, the conversation shall be recorded. The insurance company shall have up to 60 days to carry out 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. Depending on the outcome of the underwriting assessment, the insurance company shall accept or reject the insurance application or the requested extension/amendment of insurance cover, or make a proposed amendment in respect thereof. The insurance company shall not be required to give reasons for any rejection of the insurance application or of the requested extension/amendment of insurance cover, or for any proposed amendment.

II.2.12. If the **policy document is issued on terms that differ from the insurance application** or, in the case of an amendment to the policy, **from the proposed amendment** submitted by the policyholder, and the **policyholder does not object to the deviation in writing without delay, and in any event within 15 days** after receiving the policy document, **the policy shall be concluded or amended on the terms set out in the policy document**.

If the policyholder rejects or objects to the difference, the policy or amendment is not concluded. **The insurance company shall draw the policyholder's attention to any material difference in writing when the policy document is delivered.** If this notice is not given, the policy is concluded in accordance with the insurance application or the policyholder's proposed amendment.

II.2.13. **The insured's consent is not required for the conclusion, amendment or termination of the insurance policy.**

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.3. Commencement and termination of insurance cover, the waiting period and the concept of policy anniversary

II.3.1. In respect of the **insured persons specified when the insurance application is submitted**, where the policy is concluded, the insurance cover shall commence, unless otherwise agreed by the parties, at the following times:

a) in the case of **insured groups defined by headcount and insured groups defined by name** that are not subject to medical underwriting, the insurance cover shall commence on the date specified in the insurance application, provided that the policyholder has paid the insurance premium to the insurance company;

b) in the case of insured groups defined by name and **subject to medical underwriting**, the insurance cover shall commence, in respect of each insured, at 00:00 on the day following completion of the underwriting assessment in respect of that insured, provided that the insurance company agrees to provide insurance cover and the policyholder has paid the insurance premium to the insurance company. The insurance company shall notify the policyholder in writing of the commencement date of insurance cover in respect of each insured person.

II.3.2. Where the policyholder requests that the **scope of the policy be extended to new insured persons** after the policy has been concluded, insurance cover in respect of those insured persons shall commence, unless otherwise agreed by the parties, at the following times:

a) in the case of an insured belonging to an **insured group defined by headcount** (Clause III.2.10), at 00:00 on the first day of employment or, in other cases, at 00:00 on the day following notification;

b) in the case of an insured belonging to an **insured group defined by name** and not subject to medical underwriting (Clause III.2.9), at 00:00 on the day following receipt by the insurance company of the notification of change;

c) in the case of an insured belonging to an **insured group** defined by name and **subject to medical underwriting** (Clause III.2.9), at 00:00 on the day following completion of the underwriting assessment in respect of that insured, provided that the insurance company agrees to provide insurance cover. The insurance company shall notify the policyholder in writing of the commencement date of insurance cover in respect of each insured person.

II.3.3. **The insurance cover in respect of each insured shall terminate in the following cases. Upon termination of insurance cover, the insurance policy shall also terminate in respect of the insured person concerned in the following cases:**

a) if the insured dies;
   - if the insurance does not include a death benefit in respect of the given insured, the insurance policy shall terminate without payment on the date of death;
   - if the policy includes a death benefit in respect of the given insured, the policy shall terminate in respect of the given insured at the time of the insured's death, and the insurance company shall be obliged to pay the death benefit in accordance with the policy conditions or shall be entitled to reject the claim, also having regard to the provisions of Chapters VI and VII on release from benefit

payment and exclusions;

b) if insurance cover in respect of the insured was established on the basis of an insured's declaration, upon withdrawal by the insured of their insured's declaration, from 00:00 on the first day of the month following receipt by the insurance company of the withdrawal declaration;
c) in respect of the departing insured person (Clause III.2.9), from 00:00 on the first day of the month following receipt by the insurance company of the notification of change (Clause III.2.8) concerning the termination of the circumstance giving rise to insurance cover in respect of that insured person,

d) if the policyholder so requests in writing, from 0.00 a.m. on the first day of the month following the month in which the request is received by the insurance company.
e) in the case of life insurance risks, from the policy anniversary falling in the calendar year in which the insured person reaches the age of 80,
f) in the case of health insurance risks, from the policy anniversary falling in the calendar year in which the insured person reaches the age of 70,
g) in the case of accident insurance risks, from the policy anniversary falling in the calendar year in which the insured person reaches the age of 75,
h) in other cases in the manner set forth in the special conditions.

II.3.4. The **policy anniversary** shall be the first day of the month following the commencement of insurance cover specified in the insurance application.

If the period of insurance cover commences on the first day of a month, that day shall also be the policy anniversary. The parties may agree otherwise by mutual consent.

II.3.5. The insurance company **may stipulate a waiting period** of up to 6 months in the policy (hereinafter: waiting period), the first day of which shall be the commencement date of insurance cover in respect of the insured person concerned.

The insurance company shall inform the policyholder of the stipulation of a waiting period in an endorsement shown in the policy document.

During the waiting period, insurance cover shall be partial and shall extend only to accidents and insured events causally related to accidents, provided that the insurance policy provides cover for those risks.

II.4. Term of the policy

The policy is concluded for an indefinite term.

II.5. Termination of the insurance policy

II.5.1. **The policy shall terminate:**
a) in the event of non-payment of premium, at the time specified in Clause IV.5.2;
b) if the policyholder ceases to exist without a legal successor, on the date of such cessation;
c) in the event of a change in material circumstances affecting the insurance policy, and upon the insurance company becoming aware of such change, upon expiry of the 30-day notice period (Clause III.3);
d) **upon termination by the parties as set out in Clause II.5.2, or upon termination by the insurance company as set out in Clause III.3.**

II.5.2. **The policyholder and the insurance company may terminate the policy in writing with effect from the policy anniversary, no later than 30 days before the end of the insurance year (termination of the policy for convenience).**

Upon termination of the insurance policy, the status of all insured persons under the policy and, consequently, insurance cover shall terminate automatically, without any separate legal declaration or other legal act. The policyholder shall inform the insured persons of the termination of the insurance policy.

II.6. Geographical limit

Unless otherwise provided for in the special conditions, the insurance provides worldwide cover 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. Pursuant to the provisions of the policy conditions, the policyholder is required to pay the insurance premium and – unless otherwise set out in the policy conditions – is entitled to make legal statements required for the insurance policy.

III.1.2. The **policyholder is required** to inform the insured persons of the content of the insurance policy and any changes thereto.

III.1.3. The policyholder may request amendment of the policy without the consent of the insured persons. The insurance company may accept or deny the proposed amendment or may propose a modification thereof. The insurance company shall not be required to give reasons for the rejection or the proposed amendment.

III.1.4. Under the insurance policy, the insurance company is obliged to provide the benefits specified in the policy conditions.

III.2. The duty of the policyholder and the insured to disclose information and notify changes

III.2.1. The policyholder and the insured are required to disclose information and notify changes.

III.2.2. The policyholder and the insured are equally bound by the duty to disclose information and notify changes; neither of them shall be entitled to refer to any circumstance that either one had neglected to disclose or report to the insurance company although it must have known about it and should have disclosed or reported it.

III.2.3. **Under the duty of disclosure**, at the time of concluding the policy and when submitting a claim under the insurance policy, the policyholder and the insured person shall disclose to the insurance company all circumstances that are material for the acceptance of the insurance risk

and for the assessment of the claim, and of which they were or should have been aware. The parties fulfil their duty of disclosure by giving complete and truthful answers to the insurance company's questions and by making truthful declarations on the forms used by the insurance company and/or in audio recordings.

III.2.4. Based on the consent of the insured person or insured persons, the insurance company may verify the data disclosed and, for this purpose, may ask further questions concerning the insured person's health status and activities, including occupation and sport, and may require a medical examination.

III.2.5. The performance of a medical examination shall not release the policyholder or the insured person from their duty of disclosure.

III.2.6. Within a single policy, the **different insured groups may be defined in different ways**.

Depending on the method of definition, the policyholder shall provide the following data relating to the insured persons in each insured group when submitting the insurance application:

a) in the case of **insured groups defined by headcount**, the headcount and occupation of the insured persons belonging to the group;
b) in the case of **insured groups defined by name** and not subject to medical underwriting, the name, place and date of birth, sex, permanent address and occupation of the insured persons belonging to the group;
c) in the case of **insured groups** defined by name and **subject to medical underwriting**, the name, place and date of birth, sex, permanent address and occupation of the insured persons belonging to the group, and the policyholder shall obtain and submit to the insurance company the insured persons' insured's declarations and, where necessary, their medical history statements, as well as the medical examination documents.

III.2.7. At the insurance company's request, the policyholder shall provide the insurance company in writing, at any time during the term of the policy, with the list of names of the insured group defined by headcount within 10 business days of the request.

III.2.8. During the term of the insurance, the policyholder and the insured person(s) shall notify the insurance company in writing within 5 business days of any change in the material circumstances stated in the insurance application or included in the policy.

Material circumstances include all matters about which the insurance company asked a question and all matters in respect of which it required the policyholder or the insured to make a declaration, including in particular the name, address and mailing address of the policyholder and the insured, the policyholder's email address if electronic communication is selected, the data listed in Clause III.2.6, and changes in the composition, occupation and headcount of the insured group.

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

III.2.9. If the identity of the insured person (or persons) changes in an insured group defined by name, or in an insured group defined by name and subject to medical underwriting, the policyholder shall notify the insurance company in writing, within 5 business days of the date of the change, of the details specified in Clause III.2.6 in respect of the **newly joining insured** and the **departing insured person(s)**.

III.2.10. If the headcount of an insured group defined by headcount changes by more than 10% compared with the headcount last notified to the insurance company in writing, the policyholder shall provide the insurance company with the following details in writing within 5 business days:

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

III.2.11. Where an insured person in an insured group defined by name or in an insured group defined by name and subject to medical underwriting reaches any of the exit ages specified in Clauses II.3.3(e)–(g) of these conditions, the policyholder shall notify the insurance company of this circumstance at least 60 days before the policy anniversary falling in the calendar year in which the insured person reaches the relevant age.

III.3. The insurance company's right to amend or terminate the policy if material circumstances affecting the policy arise or change (material increase in risk)

III.3.1. **If, after the insurance policy has been concluded, the insurance company becomes aware of material circumstances affecting the insurance policy, or is notified of a change in material circumstances, and those circumstances result in a significant increase in the insurance risk based on the insurance company's underwriting assessment, the insurance company may, within 15 days of becoming aware of them, make a written proposal to amend the insurance policy or terminate the insurance policy, or, where there are several insured persons, only the part of the policy relating to the insured concerned, in writing, with 30 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 surplus premium or exclusions during the underwriting, or it would have denied cover.

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

III.3.2. Where the policyholder declares in writing, within 15 days of receiving the proposed amendment, that they **do not accept the proposed amendment**, the policy, or the part of the policy relating to the insured person concerned, **shall terminate** on the 30th day following communication of the proposed amendment.

If the policyholder **does not respond** within 15 days after receipt of the proposed amendment, the **policy shall be amended** in accordance with the proposed amendment on the 30th day following communication of the proposed amendment, provided that the insurance company drew the policyholder's attention to this consequence when making the proposed amendment.

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

IV. INSURANCE PREMIUM

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

IV.1.1. The insurance premium is the consideration for insurance cover. The obligation to pay the insurance premium lies with the policyholder.

IV.1.2. The entry age of the insured:

a) in the case of life insurance risks, the insured person's entry age may be between 16 and 70 years;
b) in the case of accident and health insurance risks, the insured person's entry age may be between 16 and 65 years.

IV.1.3. The insurance company shall determine the insured person's entry age by subtracting the year of the insured person's birth from the calendar year in which insurance cover commences in respect of that insured person.

IV.2. Determination of the insurance premium

IV.2.1. The insurance premium is calculated taking into account the policyholder's principal activity, the number and occupation of the insured persons, the scope of insurance cover (24-hour cover or workplace and commuting accident insurance), the insured person's health status and the sum insured or sums insured. In the cases specified in the Premium Rating Schedule, the insurance company shall also take into account the insured persons' entry age.

The insurance premium shall be recalculated taking into account any change in headcount reported by the policyholder.

IV.2.2. If the insured person's year of birth has been incorrectly stated and, as a result, a lower insurance premium than required has been determined, then, upon the occurrence of an insured event, the benefit corresponding to the insured person's correct entry age and the premium actually paid shall be paid. If, as a result of the incorrectly stated year of birth, the insurance premium paid for the policy exceeds the amount specified in the Premium Rating Schedule, the insurance company shall refund the excess premium to the policyholder within 30 days of detecting the error.

IV.2.3. If it is established that, on the basis of the actual year of birth, insurance cover in respect of the insured person could not have been established under the provisions of these conditions (Clause IV.1.2), the insurance company shall proceed in accordance with Clause III.3.1.

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. In the event of a change in headcount, or in the case of insured persons subject to underwriting, the insurance company shall adjust the insurance premium for the insured group, taking into account the amount of premium specified in Clause IV.3.1, with effect from the first day of the month following notification of the change in headcount or, in the case of underwriting, acceptance of the risk, in accordance with the changed headcount or the outcome of the underwriting assessment.

IV.4. Payment of the insurance premium

IV.4.1. The insurance policy is subject to **regular annual premium** payment. The annual premium for the insurance year may also be paid in quarterly or semi-annual instalments. Depending on the payment frequency, the insurance company may grant a premium discount.

IV.4.2. If the policyholder has received a discount affecting the amount of the premium and the circumstances giving entitlement to the discount subsequently change or cease to exist, for example due to a change in payment frequency, the policyholder shall lose entitlement to the discount and shall be required to pay the insurance premium calculated without taking the discount into account. In such a case the premium determined without the discount becomes due when the insurance company first sends out the respective payment notice (invoice) or first tries to collect the payment (by means of direct debit).

IV.4.3. The policyholder shall determine the payment frequency when submitting the insurance application and may change it on any policy anniversary, provided that the policyholder notifies the insurance company in writing of the intended change at least 60 days before the policy anniversary.

IV.4.4. The first premium for the insurance is due when the policy is concluded, and each subsequent premium is due on the first day of the period — insurance year, half-year or quarter — to which the premium relates.

IV.4.5. The policyholder fulfils its obligation to pay the insurance premium on the date on which the insurance premium is credited to the insurance company's account.

IV.4.6. The policyholder undertakes to pay the insurance premium for all insured persons in a single amount as the premium or premium instalment falls due.

IV.5. Consequences of failure to pay the premium

IV.5.1. If the policyholder fails to pay the insurance premium by its due date, the insurance company shall call upon the policyholder in writing to perform, granting an additional time limit of at least 30 days and warning the policyholder of the consequences.

IV.5.2. If the policyholder fails to meet their payment obligation **by the additional time limit set**, the insurance company shall terminate the insurance policy with effect from the paid-to date, unless the insurance company enforces its premium claim through court proceedings without delay.

IV.5.3. If only part of the premium due has been paid, and the insurance company, applying the rules on non-payment of premium as appropriate, has unsuccessfully called upon the policyholder to top up the payment, the policy shall remain in force with an unchanged sum insured for a period proportionate to the premium paid.

IV.6. Reinstatement

IV.6.1. Reinstatement means the restoration of the insurance cover of a policy terminated due to non-payment of premium, on the terms of the terminated policy.

IV.6.2. The policyholder may request in writing the reinstatement of insurance cover within 120 days of the date of termination of the policy due to non-payment of premium (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 insurance cover shall be reinstated on its original terms and for the original amount if the insurance company accepts the

request for reinstatement and notifies the policyholder of this in writing, and the policyholder pays the unpaid and due insurance premium to the insurance company no later than within 8 days of acceptance of the request.

In this case, insurance cover shall be reinstated at 00:00 on the day following payment of the outstanding premium or premium instalments, with retroactive effect to the date on which the policy terminated.

IV.6.4. Reinstatement may be requested no more than twice during the term of the insurance.

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

IV.7.1. The insurance company will adjust the sum(s) insured and the insurance premium once a year to the changes in the price level (hereinafter: annual indexation). Indexation takes effect from the policy anniversary.

IV.7.2. To determine the rate of indexation, the insurance company shall use the percentage value shown by the product of the monthly consumer price indices for the 12 months preceding the fourth month before the policy anniversary, as published in the Consumer Price Index publication of the Hungarian Central Statistical Office (hereinafter: 12-month price index), as the basis for calculating the base indexation rate. If the 12-month price index is less than 5%, the insurance company shall use 5% as the basis for calculating the base indexation rate.

IV.7.3. As part of the indexation process, the insurance company shall send a notice at least 60 days before the policy anniversary of the new sum insured or sums insured for the next insurance year and the new annual insurance premium payable from the policy anniversary. The policyholder shall have the right to reject indexation within 30 days of receiving the notice. **If the policyholder does not reject indexation within 30 days, the policy shall take effect from the policy anniversary with the increased sum insured and premium.**

IV.7.4. The insurance company shall issue a policy document on the change in the sum insured and the insurance premium within 30 days of the change, unless the insurance company communicated all changes affecting the policy in the written notice specified in Clause IV.7.3.

IV.7.5. If the parties agree on a policy anniversary date that differs from the date specified in Clause II.3.4, and there are fewer than 180 days between the commencement of insurance cover and the policy anniversary, the insurance company shall not offer indexation on that first anniversary.

IV.8. Amendment of the insurance premium

During the term of the insurance policy, the insurance company may propose an amendment to the insurance premium.

The insurance company shall communicate its proposal to amend the insurance premium to the policyholder in writing at least 30 days before the next policy anniversary.

If the policyholder does not wish to maintain the insurance policy with the amendments communicated by the insurance company, the policyholder may terminate the policy with effect from the policy anniversary before that anniversary, without regard to the notice period.

The insurance premium shall be amended, with effect from the next policy anniversary, in accordance with the insurance company's proposal if the policyholder accepts the insurance company's proposal by written declaration or accepts the proposed amendment by not exercising the termination right set out in the preceding paragraph.

V. INSURED EVENTS, INSURANCE BENEFITS AND CONDITIONS FOR BENEFIT PAYMENT BY THE INSURANCE COMPANY

V.1. Insured events

For the purposes of insurance policies concluded pursuant to these general conditions and the related special conditions, insured events shall be events defined as such in the special conditions.

V.2. Insurance benefits

If the insured events specified in the special conditions occur, the insurance company shall provide the insurance benefit specified in the special conditions. The insurance company shall reimburse only the costs specified in the policy conditions. The insurance company shall reimburse costs incurred in connection with submitting a claim only if it expressly undertook to do so under the special conditions.

V.3. Conditions for benefit payment by the insurance company

V.3.1. Method and time limit for notifying the insurance company of an insured event

The insured event must be notified to the insurance company **within 15 days** of its occurrence.

The **insurance company may be released from its obligation to pay the benefit** if material circumstances relevant to its obligation become impossible to ascertain as a result of **failure to observe the above time limit**, **failure to provide the information deemed necessary by the insurance company** for assessing the claim, or failure to make it possible to verify the content of the information provided.

V.3.2. Documents required for payment by the insurance company

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

V.3.2.1. proof of employment (Clause IX.3) in respect of the insured person concerned, such as an employer's certificate;

V.3.2.2. if the accident occurred at the workplace or while performing work, an accident report prepared in writing by the policyholder, stating the place of the accident, the exact time of the accident, the personal data of the person who suffered the accident, the detailed circumstances and consequences of the accident, and the data and contact details of any witnesses;

V.3.2.3. if necessary, the verification of the fact that the particular insured is covered under the insurance policy.

V.3.2.4. **the claim form provided by the insurance company, completed in full;**

V.3.2.5. the documents specified in the applicable special conditions.

V.3.2.6. **The documents necessary to clarify the immediate circumstances and consequences of the insured event** (including the declarations of the insured person and any other person affected by the insured event concerning the circumstances of the insured event, accident reports or decisions prepared by the police, workplace, educational institution or transport company, and expert opinions relating to the accident or its consequences);

V.3.2.7. **the form** provided by the insurance company and **completed by the insured person's treating physician or by the healthcare provider treating the insured person, concerning health data relating to the insured event, the insured person's health status and the insured person's medical history;**

V.3.2.8. the **insured's medical documents** relating to the insured event and medical-history data: a copy of the medical record kept by the general practitioner, occupational physician or competent staff physician, documents generated during outpatient and inpatient care, and documents evidencing medication use;

V.3.2.9. **documents containing data relating to the insured person and relating to the insured event or the circumstance giving rise to it,** held by the social security body or by another person or organization, based on the authorisation of the entitled person necessary for release from confidentiality and for requesting data;

V.3.2.10. The insured's **membership card**, document evidencing legal relationship or match report **relating to any sports activity** that affects the insurance company's cover;

V.3.2.11. An official certificate in proof of the insured's date of birth;

V.3.2.12. The insured or beneficiary may also substantiate their insurance claim by other documents under the general rules of evidence in order to enforce their claim. For example, they may also submit to the insurance company a final decision adopted in criminal proceedings or petty-offence proceedings.

V.3.2.13. The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.

V.3.2.14. The insurance company may require the **submission of certified Hungarian translations**, prepared at the expense of the person submitting the insurance claim, of **all foreign-language documents** necessary for the decision to be made on the claim;

V.3.2.15. The insurance company **may require that original copies of such documents are presented** and that they are also submitted on a form of electronic media chosen by the customer;

V.3.2.16. The insurance company is entitled to obtain additional documents for the assessment of the insurance claim if such documents are requested within 15 days of receipt of the insurance claim and the request is communicated to the customer.

V.3.3. Due date of benefit payment by the insurance company

V.3.3.1. The insurance claim notified to the insurance company shall become due on the 15th day following receipt of the last document necessary for claim settlement by the insurance company; the documents necessary for claim settlement are those which prove the ground and the amount of the insurance claim. The death benefit will be paid out only after the due diligence of the policyholder and the beneficiary has been completed, provided that it is required pursuant to Act LIII of 2017 on the Prevention and Combating of Money Laundering and Terrorist Financing. When documents are obtained, the insurance company is required to pass a decision about the claim within 120 days after receiving the insurance claim, and shall communicate the decision to the customer.

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

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

V.3.3.4. The costs of the personal medical examination shall be borne by the insurance company. The insured bears any costs incurred in connection with attending the personal medical examination.

VI. RELEASE OF THE INSURANCE COMPANY FROM THE OBLIGATION TO PAY BENEFITS

VI.1. Release of the insurance company from the obligation to pay life, accident and health insurance benefits

VI.1.1. **If the policyholder or the insured breaches their duty of disclosure or notification of changes, the insurance company's obligation to pay benefits does not arise, unless the policyholder proves that one of the following circumstances exists:**

a) the insurance company knew the concealed or unreported circumstance when the policy was concluded; or

b) the policyholder and/or the insured infringed their duty to communicate changes, but the concealed or unreported circumstance has come to the knowledge of the insurance company during the policy term prior to the insured event, and the insurance company failed to exercise its rights set forth in Clause III.3. of these general conditions to amend or terminate the insurance policy within 15 days, or

c) the concealed or unreported circumstance did not contribute to the occurrence of the insured event.

VI.1.2. **The existence of the listed circumstances shall be proven by the person to whom they relate.**

VI.2. In addition to the cases listed in Clause VI.1 above, the insurance company shall be exempted from the payment of life insurance benefits if:

a) the cause of the insured's death is suicide committed within two years of the date on which the insurance policy was concluded, even if the insured was in a disturbed state of mind when committing the 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 person dies as a result of the beneficiary's intentional conduct, in which case the insurance company's benefit shall

be payable to the insured person's heirs and the beneficiary shall not be entitled to any part of it.

VI.3. In addition to the cases listed in Clause VI.1 above, the insurance company shall be exempted from the payment of health and accident insurance benefits if:

a) the insured dies as a consequence of willful conduct by the beneficiary.
b) the insurance company proves that the loss was caused unlawfully, by intentional or grossly negligent conduct, by:
   – the policyholder or the insured person;
   – a relative living in the same household as them, their member authorized to manage the business, or their employee, member or agent holding a position specified in the general terms and conditions; or
   – in the case of an insured legal person, its senior officer specified in the general terms and conditions, or its member, employee or agent authorized to manage the insured property.

When an event underlying an insured event occurs, the insured must act in the manner generally expected in the given situation and must therefore seek medical or healthcare assistance without delay. However, it shall not constitute a breach of the duty to mitigate loss if the insured, exercising their statutory right of self-determination, does not consent to a medical intervention.

The insured must act as generally expected in the given situation to prevent the occurrence of an insured event. If the insured person fails to comply with their loss prevention or loss mitigation obligation, the insurance company shall be released from its obligation to pay the benefit.

VII. EVENTS EXCLUDED FROM THE INSURANCE COVER

VII.1. Exclusions applicable to life, accident and health insurance risks

VII.1.1. The insurance cover does not extend to events caused in whole or in part by:

a) ionizing radiation,
b) nuclear energy;
c) HIV infection;
d) war, acts of war, hostile acts of a foreign power, disturbances, coup or attempted coup against the government, mutiny, civil war, revolution, rebellion, demonstration, march, strike, terrorist act, workplace disorder, border skirmish or uprising.

VII.1.2. For the purposes of these general conditions, an act of terrorism includes in particular any violent act or threat of violence that endangers human life, tangible or intangible property, or infrastructure, and that either advocates political, religious, ideological or ethnic objectives, or is intended or suitable to influence a government or to intimidate society or part of society.

VII.1.3. Notwithstanding Clause VII.1.1(d), the insurance cover extends to impairments in the insured's health arising in connection with the insured's active participation in demonstrations, strikes or marches that have been notified in advance and held in accordance with the provisions of the Hungarian laws in force, provided that the insured has complied with their obligation to prevent and mitigate the loss.

VII.1.4. The insurance company shall not be liable for events arising out of or caused in whole or in part by the events listed hereunder:

a) an illness or pathological condition of the insured that demonstrably existed in the three years before commencement of cover in respect of the given insured, or that was diagnosed within the three years preceding cover, or that required medical treatment or medical supervision during that period;
b) any permanent health impairment of the insured person established before insurance cover in respect of that insured person commenced.

For the purposes of this paragraph, congenital abnormality or acquired disability means any degree of deficiency in physical and/or mental integrity.

VII.1.5. The insurance cover does not extend to an event occurring while the insurance policy (the insurance cover) is in force if

a) the event occurred in connection with the insured's regular consumption of alcohol, use of narcotic drugs, or use of psychoactive substances or medication, unless the latter were used as prescribed by the insured's treating physician and in accordance with that prescription,
b) the insured was verifiably under the influence of alcohol, a narcotic drug, a psychoactive substance or medication at the time of the event. If a blood alcohol test was carried out, for the purposes of this clause, a blood alcohol concentration exceeding 1.5‰, or exceeding 0.8‰ while driving a motor vehicle, shall be deemed to constitute being under the influence of alcohol.
c) the insured was driving a motor vehicle without a valid vehicle registration certificate or without a valid driver's license required for driving such vehicle, while at the same time also committed other traffic violations;
d) the insured was driving a motor vehicle under the influence of alcohol when the insured event occurred and at the same time also committed other traffic violations.

VII.2. Exclusions applicable to accident and health insurance risks

VII.2.1. The insurance cover does not extend to events caused in whole or in part by:

a) assisted reproduction in any form,
b) events related exclusively to treating infertility,
c) events related to infertility treatment procedures involving healthcare services intended to reverse the consequences of sterilization performed for non-medical reasons or to restore the original condition,
d) sterilization,
e) gender reassignment,
f) treatment or surgery performed for aesthetic purposes and its consequences;
g) prosthodontic treatment.

VII.2.2. The insurance cover does not extend to events caused in whole or in part by:

a) hospital care whose purpose is not to diagnose the insured's illness, prevent deterioration in the insured's health or restore the insured's health, including in particular screening examinations, a parent's hospital stay on account of their child, or the insured's hospital stay to care for their parent,
b) incapacity for work whose purpose is not to diagnose the insured person's illness, prevent deterioration in the insured person's state of health or restore the insured person's health, including in particular incapacity for work due to screening examinations

or a parent's, foster parent's or substitute parent's incapacity for work in connection with caring for a sick child,

c) rehabilitation and care of chronic illnesses, in particular geriatric care, special needs education, speech therapy, therapeutic exercise, physical therapy, spa treatment, weight-loss treatment, and infusion treatments to improve circulation or relieve pain, except for treatments relating to the diagnosis of chronic illnesses, the initial setting of medical treatment, or the management of significant acute deterioration in condition,

d) treatment provided by a person who does not have a medical qualification and operating license.

VII.2.3. The insurance does not cover mental-function disorders or psychiatric illnesses.

VII.2.4. **Insurance cover shall not extend to health insurance events caused by the insured person's suicide or attempted suicide, even if the insured person was in a disturbed state of mind at the time of the act.**

VII.2.5. **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 cover applicable to the particular insured. The insurance company shall consider conception to have occurred before the commencement of insurance cover if there are fewer than 285 days between the commencement of insurance cover in respect of the insured person concerned and the expected date of delivery recorded in the official document evidencing the pregnancy, such as the maternity booklet.**

VII.2.6. **Except in relation to accident insurance risks, insurance cover shall not extend to induced termination of pregnancy, except where the termination is performed to preserve the mother's health or save her life, where there is a fetal developmental abnormality supported by appropriate diagnostic testing, or where the pregnancy resulted from a criminal offence.**

VII.2.7. **In the event that the insured requires life saving intervention as a result of any of the events listed in Clauses VII.2.1., VII.2.5., and VII.2.6., the insurance will cover the events which are the result of the conditions requiring medical care.**

VII.3. Exclusion of sports-related harm

Insurance cover shall not extend to events that are causally related to the insured person's sports activity classified as an extreme risk and listed in Annex "C" to these general conditions.

VIII. MISCELLANEOUS PROVISIONS

VIII.1. Limitation period

The limitation period for claims enforceable under the policy is 2 years.

The limitation period begins at the following times:

a) if the insured event is not notified, when the insured event occurs;

b) if the insured event is notified, on the day following the 15th day after receipt by the insurance company of the last document;

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 set for submitting the documents or providing the information 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, on the day the claim becomes due.

VIII.2. Loss or destruction of the policy document

If the policy document is destroyed or lost, the insurance company shall, at the policyholder's request, issue a new policy document with content identical to the current data.

VIII.3. Procedure in case of disagreement

If the customer disputes the insurance company's position on a claim, the customer may request a review of the decision in writing. The competent organizational unit of the insurance company shall make a decision within 30 days of receiving all documents/data required for assessing the request and shall notify the applicant of the decision.

IX. TERMS AND DEFINITIONS

IX.1. Definitions of accident, workplace accident, commuting accident and traffic accident

IX.1.1. For the purposes of these general conditions, **accident** means a sudden, one-off external physical and/or chemical effect that affects the insured person against their will during the period of insurance cover and in connection with which the insured person suffers health impairment or dies.

IX.1.2. For the purposes of these general conditions, the following **shall also be considered accidents**:

a) poliomyelitis and meningitis and/or encephalitis resulting from a tick bite, if the disease has been diagnosed by serological testing and appears no earlier than 15 days after the commencement of insurance cover and no later than 15 days after its termination. The date of onset of the disease shall be the date on which medical attention was first sought for the disease diagnosed as poliomyelitis or as meningitis and/or encephalitis;

b) rabies, if the disease has been diagnosed and appears no earlier than 60 days after the commencement of insurance cover and no later than 60 days after its termination. The date of onset of the disease shall be the date on which medical attention was first sought for the disease diagnosed as rabies;

c) tetanus infection, if the disease has been diagnosed and appears no earlier than 20 days after the commencement of insurance cover and no later than 20 days after its termination. The date of onset of the disease shall be the date on which medical attention was first sought for the disease diagnosed as tetanus infection.

IX.1.3. For the purposes of these general conditions, except as provided in Clause IX.1.2, the **following shall not be considered accidents**:

a) the entry or introduction of live pathogens (bacteria, viruses, protozoa) from a human or animal host organism (carrier) into a human host

organism (hereinafter collectively: transmission), even if the transmission is caused by an accident-like physical cause, unless the special conditions provide otherwise;
b) occupational disease or harm;
c) the insured person's suicide or attempted suicide, even if it occurs while the insured person is in a disturbed state of mind;
d) pathological fractures of bones and recurrent, habitual dislocation;
e) the development of a herniated disc, unless the herniated disc is the consequence of a single, extreme mechanical impact directly affecting an otherwise intact intervertebral disc from the outside;
f) the development of an abdominal hernia, unless the abdominal hernia is the consequence of a single, extreme mechanical impact directly affecting an otherwise intact abdominal wall from the outside;
g) damage to articular cartilage, ligaments or other soft tissues, unless the damage is the consequence of a single, extreme mechanical impact directly affecting an otherwise intact joint from the outside.

IX.1.4. For the purposes of these general conditions, **workplace accident** means an accident sustained by the insured person while performing activities within the scope of their occupation or in connection with such activities.

An accident occurring in causal connection with work performed without authorization shall not be considered a workplace accident.

IX.1.5. For the purposes of these general conditions, **commuting accident** means an accident sustained by the insured person while travelling by the shortest route from their home or accommodation to work, or from work to their home or accommodation.

IX.1.6. For the purposes of these general conditions, **traffic accident** means an accident sustained by the insured person as a pedestrian, as the driver of a vehicle or as a passenger.

IX.1.7. For the purposes of these general conditions, **the following shall not be considered traffic accidents**:
a) an accident involving a pedestrian where no moving vehicle contributed to the occurrence of the accident;
b) an accident involving a cyclist where the movement of another vehicle or a pedestrian did not contribute to the accident;
c) an accident involving a passenger of a vehicle that did not occur in connection with the movement or stopping of that vehicle or another vehicle.

IX.2. Definitions of illness, hospital, surgery and the surgical list

IX.2.1. For the purposes of these general conditions, **illness** means an abnormal condition affecting the functioning of the human body.

IX.2.2. For the purposes of these general conditions, **hospital means** an institution providing licensed inpatient care, recognized by the Hungarian public health authority and professional supervisory body, and operating under continuous medical management and supervision.

IX.2.3. For the purposes of this insurance, sanatoria, rehabilitation institutions, medical spas, health resorts, institutions for the treatment and care of persons with mental illness, geriatric care providers, residential care homes, alcohol and drug detoxification institutions, nursing institutions, other institutions providing "chronic" inpatient care, and hospital wards or ward sections providing services of the above nature **shall not be considered hospitals**, even if inpatient hospital treatment is provided there, provided that the insured received a service corresponding to that nature of the ward.

IX.2.4. For the purposes of these general conditions, surgery means a medical procedure during which, in accordance with professional medical standards and with the intention of preserving health, curing disease or mitigating its consequences, the continuity of the skin and/or mucous membranes is breached.

IX.2.5. The insurance company classifies surgical procedures into groups (hereinafter: classification of surgeries). This categorization of surgical procedures with the applicable insurance benefit rates (hereinafter: List of Surgeries) is set out in Annex "B" to these General Conditions. For the purposes of surgical benefit payment, the insurance company has assessed all WHO-coded surgical procedures, with the proviso that any surgical procedures not falling within any of the groups listed in the Surgical List fall into surgical benefit category 5, "non-covered" (e.g. diagnostic tests and procedures, including histological sampling procedures and cytology tests, injection and infusion treatments, physiotherapy and chemotherapy).

IX.2.6. Termination of pregnancy due to a fetal health condition

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

IX.3. Definition of employment

For the purposes of these general conditions, employment means indefinite-term employment of at least 30 hours per week, including (i) employment falling within the scope of the Act on the Labor Code ("Labor Code"), and the following relationships governed by Hungarian law: (ii) public service or civil servant employment, (iii) public employee employment, (iv) judicial, justice-sector or prosecutorial service, (v) the service relationship of professional and contracted members of the armed forces and law enforcement agencies, government official employment, and any other work-related legal relationship under which the insured becomes entitled to jobseeker's allowance in Hungary. Employment also includes fixed-term employment or another legal relationship for the performance of work concluded for at least 12 months and involving at least 30 hours of work per week. Insurance cover extends only to Employment as referred to in this Clause.

X. PROVISIONS OF THE GENERAL CONDITIONS MATERIALLY DEVIATING FROM THE CIVIL CODE AND FROM USUAL CONTRACTUAL PRACTICE

This chapter sets out, in summary form, the provisions of the general terms and conditions of Pajzs Employer's Group Insurance that materially deviate from the provisions of the Civil Code and from standard contractual practice.

X.1. Provisions of the general conditions materially deviating from the Civil Code and from standard contractual practice

X.1.1. Conclusion, amendment and termination of the insurance policy

Pursuant to Clause II.1.5 of these conditions, and by way of derogation from Section 6:478(2) of the Civil Code, unless otherwise agreed by the parties, **by signing the insurance application the policyholder consents to the insured person or insured persons designating or**

changing a beneficiary in writing during the period of their insurance cover, without any separate declaration by the policyholder, and shall inform the insured persons thereof.

Pursuant to Clause II.2.12 of these conditions, and by way of derogation from Section 6:443(2) of the Civil Code, the policyholder may object to any deviation contained in a policy document issued on terms differing from the insurance application without delay, and **in any event within 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 insured person's consent is not required for the conclusion, amendment or termination of the insurance policy**.

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 stipulate a waiting period of up to 6 months in the policy (hereinafter: waiting period), **the first day of which shall be the commencement date of insurance cover in respect of the insured person concerned**.

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

Pursuant to Clause III.3.2 of these conditions, and by way of derogation from Section 6:446 (2) of the Civil Code, if the policyholder **does not respond within 15 days of receipt of the proposed amendment, the policy is amended in accordance with the proposed amendment on the 30th day** after the proposed amendment is communicated, provided that the insurance company drew the policyholder's attention to this consequence when making the proposed amendment.

X.1.2. Setting an additional payment deadline

Pursuant to Clause IV.5.1. of these conditions, and by way of difference from Section 6:449 (1) of the Civil Code, the insurance company will send the policyholder a written payment reminder granting an additional deadline of **at least** 30 days if the policyholder fails to settle the insurance premium by the due date.

X.1.3. 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 may exercise, without limitation during the term of the policy, its rights arising from any breach of the duty of disclosure or notification of changes.

X.1.4. Limitation period

The provision on limitation in Clause VIII.1 of these policy conditions differs from the general 5-year limitation period specified in Section 6:22 (1) of the Civil Code. Claims arising from this policy become time-barred after **2 years**.

Effective from: June 26, 2026.

Annex "A"
Permanent Health Impairment

The table referred to in the Special Conditions of accident-related permanent health impairment insurance and permanent health impairment insurance arising from a traffic accident is used to determine the insurance company's benefit.

The purpose of this table is to illustrate the principle for determining the insurance benefit.

The degree of permanent health impairment is determined by the insurance company's physician as follows:

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

Annex “B"
Classification of Surgical Groups by Surgical Benefit Categories

List of surgical procedures by benefit category and percentage of the sum insured payable:

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

for surgery in Group 2, 50% of the sum insured
- head and neck surgery (excluding skin, mucous membrane and subcutaneous lesions), except thyroid, parathyroid and tracheostomy
- open thoracic surgeries (e.g. lung, mediastinum, oesophagus, lymph node surgeries), except cardiac surgeries
- coronary artery surgeries
- open surgeries on the thoracic and abdominal aorta and vena cava

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

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

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

Annex "C"
Extreme Sports Risks

auto-crash (demolition derby) sport; caving, cave expeditions; base jumping; scuba diving below a depth of 40 m; canyoning; go-kart racing; mountaineering, rock climbing of grade V difficulty or higher; hot-air ballooning; hydrospeed; airship flying; high-altitude expeditions; bungee jumping; motocross; powerboat racing; motorcycle racing; aerobatics; piloting a parafoil wing, parafoil parachuting; quad biking; rallying; piloting hang gliders and ultralight aircraft; paragliding; sport aviation, parachute jumping; car skill competitions; white-water rafting; extreme car racing; sailing: single-handed, offshore; piloting gliders and powered aircraft.

Annex "D"
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. **Mining workers:** mining machinery operators, mining technicians, deep-drilling workers, miners, assistant miners, mine-car operators, quarry workers, stone crushers, oilfield workers and workers engaged in the extraction of solid minerals.
4. **Metallurgical workers:** metallurgical machinery operators, metallurgical technicians, foundry workers, boiler operators, ferrous and non-ferrous metal smelters, and rolling-mill workers.
5. **Workers dealing with explosives and highly flammable substances:** shot-firers and blasters, pyrotechnists.
6. **Electrical power workers:** electrical power technicians, skilled workers and unskilled workers.
7. **Industrial alpinists**
8. **Industrial divers**
9. **Occupations involving the carrying of weapons:** bodyguards, commandos, foreign legionnaires, intelligence officers, armed guards, armed guards in correctional institutions, correctional officers, prison guards, security guards, security guards carrying weapons for self-defence, cash-in-transit guards, and professional members and conscripts of the armed forces engaged in activities involving increased risk, such as bomb disposal specialists and divers.
10. **Peacekeepers**
11. **Radioactive decontamination equipment operator**
12. **Stuntman**

Special conditions of insurance cover for accident-related death (KBHAT/02026)

These special conditions apply to the **accidental death cover under Pajzs group insurance policies** offered by Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy is concluded with reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. The insured event means an accident (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured dies within one year after the accident.**

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. **If an insured event specified in the insurance policy occurs, the insurance company shall pay to the beneficiary entitled to the death benefit the sum insured specified for this insurance risk in the policy document or indexation letter** in force at the time of death**.**

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 person'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 respect of this risk on the last policy document in force or in the last indexation letter**.

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the relative's copy of the death investigation certificate/death case summary,
b) the autopsy report, if one was prepared,
c) the insured's certificate of death,
d) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
e) the accident / workplace accident / police report, if one was prepared,
f) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
g) in the case of a traffic accident, in addition to the above:
if the insured **was injured** or died as **the driver of a vehicle** in a traffic accident, 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.
i) if the insured dies abroad, an attested Hungarian translation of the certificate issued by the foreign authority about the circumstances of the death,

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for accident-related death in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related permanent health impairment with linear benefit (KBROK/02026)

These special conditions apply to the accident-related permanent health impairment **insurance risk with linear benefit payment under the Pajzs group insurance policies of Generali Biztosító Zrt.** (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. The insured event means an accident (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured suffers permanent health impairment.**

I.2. **Health impairment** means any **reduction in physical and/or mental functional capacity that restricts the person's usual way of life.**

I.3. **Health impairment shall be considered permanent if it can be regarded as medically established and stable.** Where the degree of health impairment **continues to change**, but **two years have elapsed from the date of the accident**, **after that two-year period the insurance company's medical expert shall determine the degree of demonstrably existing health impairment**, which the insurance company shall regard, for the purposes of its benefit payment obligation and the amount of the benefit, as **permanent health impairment** resulting from the accident. When permanent health impairment is determined, **any change in working capacity and/or any forced discontinuation of sports activity shall not be relevant. No adverse aesthetic effect** or other **(social, financial, etc.) detriment** arising out of or in relation to the accident **shall in itself be grounds for an insurance claim** with respect to permanent impairment.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. The insurance company shall **pay a benefit only if permanent health impairment exists** (Clause I.3 of these special conditions).

II.2. **If an insured event occurs, the insurance company shall pay a percentage of the sum insured stated in respect of this covered risk in the policy document in force at the time when the degree of permanent health impairment is established – or if the insurance policy was already terminated, in the last effective policy document – or in the indexation letter, corresponding to the extent of the permanent health impairment, subject to Clause II.9 of these special conditions.**

II.3. **The degree of permanent health impairment** serving as the basis of the benefit **shall be determined by the insurance company's physician with reference to the table in Annex "A", which forms an integral part of the general conditions applicable to the policy.**

II.4. If the **degree of health impairment cannot be determined on the basis of the table**, the benefit shall be determined **on the basis of the medically assessed reduction in physical and/or mental integrity**.

Organs or body parts that were already permanently impaired and not intact before the accident shall be excluded from insurance cover up to the degree of the pre-existing impairment.

The degree of health impairment determined in the expert opinion of the **Medical Expert Institute** (the body authorised under Hungarian legislation in force from time to time to determine the degree of health impairment/state of health), or in the **decision of the pension insurance administrative body**, shall not be relevant for the degree of health impairment to be determined by the insurance company's physician or for determining the 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 nature of the impairment or the extent of any permanent health impairment.

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

II.6. **If the insured person dies before the health impairment becomes definitive, the benefit shall be payable on the degree of health impairment which, based on the records of the most recent medical examination, the insurance company's physician considers may be taken into account.**

II.7. **No benefit claim** for permanent health impairment **may be made if the insured person dies within 15 days after the accident.**

II.8. **If the insurance company has already established its benefit payment obligation but the amount payable** as a benefit **cannot yet be determined, the insured person may require the insurance company to pay the minimum amount due to the insured person** on the basis of the facts of the case.

II.9. **Where, following payment** by the insurance company**, the insured person's state of health continues to deteriorate as a consequence of the same insured event on the basis of which the insurance company has already paid a benefit, the insured person may, by submitting medical documents evidencing deterioration** despite appropriate medical treatment, **submit a repeated benefit claim once per year per insured event,** for no more than four years from the date of the reported accident, **requesting a review of their state of health and a renewed determination of the degree of permanent health impairment.** Where deterioration is established by the insurance company's physician, the insurance company shall pay the benefit on the basis of the sum insured recorded in the policy document or indexation letter in force at the time of the review, **deducting from the subsequent benefit payable any amounts previously paid in connection with the above insured event**.

Even in this case, the degree of permanent health impairment established as a consequence of the same insured event **may not exceed 100%.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
b) the accident/workplace accident report, if one was prepared,
c) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
d) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,
e) other documents required to clarify the circumstances of the accident.

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

III.6. **Where the legal basis of the claim has been acknowledged, the insurance company shall pay the benefit within the following time limits:**

a) the benefit determined **on the basis of medically clearly established permanent health impairment**: **within 15 days after receipt of the last document** required to assess the benefit claim;
b) in other cases: **within 15 days after the permanent health impairment becomes definitive, but no later than within 15 days after the expiry of 4 years following the accident.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for accident-related permanent health impairment in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related permanent health impairment with progressive benefit (KBROK/12026)

These special conditions apply to the **insurance cover for accident-related permanent health impairment with progressive benefit under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. The insured event means an accident (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured suffers permanent health impairment.**

I.2. **Health impairment** means any **reduction in physical and/or mental functional capacity that restricts the person's usual way of life.**

I.3. **Health impairment shall be considered permanent if it can be regarded as medically established and stable.** Where the degree of health impairment **continues to change**, but **two years have elapsed from the date of the accident**, **after that two-year period the insurance company's medical expert shall determine the degree of demonstrably existing health impairment**, which the insurance company shall regard, for the purposes of its benefit payment obligation and the amount of the benefit, as **permanent health impairment** resulting from the accident. **Any change in working capacity and/or any forced discontinuation of sports activity shall not be relevant** when determining permanent health impairment. Adverse aesthetic consequences and other disadvantages, **including social or financial disadvantages**, resulting from the accident **shall not, in themselves, constitute grounds for a benefit claim** for permanent health impairment.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. The insurance company shall **pay a benefit only if permanent health impairment exists** (Clause I.3 of these special conditions).

II.2. **Upon the occurrence of an insured event, the insurance company shall pay, as a benefit, the percentage specified in this Clause for the degree of permanent health impairment, calculated on the sum insured recorded for this insurance risk in the policy or indexation letter in force at the time when the degree of permanent health impairment is determined, or, after termination of the policy, in the last policy or indexation letter in force, also having regard to Clause II.9 of these special conditions.**

The percentage values determining the amount of the progressive benefit, depending on the degree of permanent health impairment, are as follows:

For permanent health impairment below 26%, the percentage value determining the amount of the benefit is equal to the degree of health impairment. In all other cases, **the percentage value assigned to the percentage degree of permanent health impairment is as follows:**

degree of health impairment → benefit %	degree of health impairment → benefit %	degree of health impairment → benefit %	degree of health impairment → benefit %	degree of health 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 degree of permanent health impairment** on which the benefit is based **shall be determined by the insurance company's physician with reference to the table in Annex "A", which forms an integral part of the general conditions applicable to the policy.**

II.4. If the **degree of health impairment cannot be determined on the basis of the table**, the benefit shall be determined **on the basis of the medically assessed reduction in physical and/or mental integrity**.

Organs or body parts that were already permanently impaired and not intact before the accident shall be excluded from insurance cover up to the degree of the pre-existing impairment.

The degree of health impairment determined in the expert opinion of the **Medical Expert Institute** (the body authorised under Hungarian legislation in force from time to time to determine the degree of health impairment/state of health), or in the **decision of the pension insurance administrative body**, shall not be relevant for the degree of health impairment to be determined by the insurance company's physician or for determining the benefit amount payable by the insurance company. **The insurance company shall not be bound by any decision or expert opinion of another medical expert body when determining the permanent nature of health impairment or the degree of permanent health impairment.**

II.5. **Permanent health impairment** established as the consequence of a single insured event **may not exceed 100%**.

II.6. **If the insured person dies before the health impairment becomes definitive, the benefit shall be payable on the degree of health impairment which, based on the records of the most recent medical examination, the insurance company's physician considers may be taken into account.**

II.7. **No benefit claim** for permanent health impairment **may be made if the insured person dies within 15 days after the accident.**

II.8. **If the insurance company has already established its benefit payment obligation but the amount payable** as a benefit **cannot yet be determined, the insured person may require the insurance company to pay the minimum amount due to the insured person** on the basis of the facts of the case.

II.9. **Where, following payment** by the insurance company**, the insured person's state of health continues to deteriorate as a consequence of the same insured event on the basis of which the insurance company has already paid a benefit, the insured person may, by submitting medical documents evidencing deterioration** despite appropriate medical treatment, **submit a repeated benefit claim once per year per insured event,** for no more than four years from the date of the reported accident, **requesting a review of their state of health and a renewed determination of the degree of permanent health impairment.** Where deterioration is established by the insurance company's physician, the insurance company shall pay the benefit on the basis of the sum insured recorded in the policy document or indexation letter in force at the time of the review, deducting from the subsequent benefit payable any amounts previously paid in connection with the above insured event.

Even in this case, the degree of permanent health impairment established as a consequence of the same insured event **may not exceed 100%.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) all medical documents issued in connection with the insured event between the accident and the notification of the benefit claim, in particular the records of the first medical treatment;
b) the accident/workplace accident report, if one was prepared,
c) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
d) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,
e) other documents required to clarify the circumstances of the accident.

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

III.6. **Where the legal basis of the claim has been acknowledged, the insurance company shall pay the benefit within the following time limits:**

a) the benefit determined **on the basis of medically clearly established permanent health impairment**: **within 15 days after receipt of the last document** required to assess the benefit claim;
b) in other cases: **within 15 days after the permanent health impairment becomes definitive, but no later than within 15 days after the expiry of 4 years following the accident.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for accident-related permanent health impairment in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Special conditions of insurance cover for bone fracture (KBCST/02026)

These special conditions apply to the **bone fracture cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means an accident (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person suffers a bone fracture or bone fissure**.
For the purposes of these special conditions, **tooth fracture shall not be considered a bone fracture**.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

If an insured event occurs, the insurance company **shall pay, per accident and irrespective of the number of fractures, the sum insured recorded for this insurance risk in the policy document or indexation letter** in force at the date of the insured event **or, after termination of the policy, in the last policy document or indexation letter in force.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**
a) the radiology (x-ray) report or medical certificate confirming the fracture,
b) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
c) the accident/workplace accident report, if one was prepared,
d) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
e) in the case of a traffic accident, in addition to the above:
– the police report, if one was prepared,
– if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for bone fracture in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for injuries with a recovery period exceeding 14 or 28 days (KBSER/02026)

These special conditions apply to the **insurance risk for injuries with a recovery period exceeding 14 or 28 days under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

Matters not regulated by these Special Conditions shall be governed by the **General Conditions of Pajzs Group Insurance** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means an **accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person suffers an injury with a recovery period exceeding 14 or 28 days**. For the purposes of these special conditions, an **injury shall be considered to have a recovery period exceeding 14 or 28 days** if, as a result of the injury, the **insured person is certified by a physician as being unable to work for at least 14 or 28 consecutive calendar days within one year of the date of the accident**, or, in the case of a minor insured person who is a student, is exempted by a physician from the obligation to attend school.

I.2. **Multiple successive recovery periods arising from the same accident shall not be added together.**

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. If an insured event occurs, the insurance company **shall pay the sum insured specified for this insurance risk in the policy document or indexation letter in force at the time of the insured event or, after termination of the policy, in the last policy document or indexation letter in force,** based on the number of benefit days specified in the insurance application (14 or 28 days).

II.2. The insurance company shall not pay any benefit for the first number of days of incapacity for work specified in the policy (14 or 28 days).

II.3. **The sum insured may be paid once in respect of any one accident.**

II.4. The insurance company's benefit shall be understood by reference to the number of days stated in the insurance application.

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) a medical certificate confirming a recovery period exceeding 14 or 28 days,
b) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
c) the accident/workplace accident report, if one was prepared,
d) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
e) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, in the cases specified in Chapter VI of the general conditions, the insurance company shall be released from its obligation to pay the benefit for injuries with a recovery period exceeding 28 days, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for soft tissue injuries (KBLSE/02026)

These special conditions apply to the **insurance cover for soft tissue injuries under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

In matters not regulated in these special conditions, the **general terms and conditions of Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy has been concluded, **shall apply**.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means an **accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which any of the following events occurs in respect of the insured person**:

a) **dislocation** means a position of the two bones forming the shoulder, elbow, wrist, hip, knee or ankle joint that differs from their anatomical position and does not regain its original anatomical position, either spontaneously or through external intervention, before it is documented by imaging examination.
For the purposes of these special conditions, the following shall not be considered dislocation:
- recurrent, habitual dislocation; and
- dislocation of a body part that had already sustained a dislocation before the commencement of insurance cover.

b) **ligament rupture** means rupture of a ligament of a joint, supported by ultrasound or MRI examination, or by medical documents and a surgical report, where surgery of the injured joint is performed within one week of the date of the accident, such as ligament repair or ligament reconstruction, or the injured joint is immobilised for at least four weeks, such as in a plaster cast or rigid plastic brace.

c) **muscle or tendon rupture**: rupture of any muscle or tendon to such an extent that it is surgically repaired within one week of the date of the accident.

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

II. INSURANCE CLAIMS AND LIMITATIONS TO CLAIMS PAYMENT

II.1. If an insured event occurs, the insurance company shall **pay, per accident and regardless of the number of events specified in Section I.1, up to the sum insured specified for this insurance risk in the policy document or indexation letter** in force at the time of the insured event or, **after termination of the policy, in the last policy document or indexation letter in force.**

II.2. **If a particular joint is injured multiple times, the insurance only pays out once within any one policy year.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after 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 shall be exempt from the payment of the insurance benefit**.

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) **the following must always be submitted:**
- all medical documentation relating to the insured event and produced between the accident and notification of the claim, in particular the documents relating to the first medical treatment,
- the accident/workplace accident report, if one was prepared,
- the blood alcohol and/or psychoactive substance test result, if one was performed,
- in the case of a **traffic accident**, in addition to the above:
  i. the police report, if one was prepared,
  ii. if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,
- other documents required to clarify the circumstances of the accident.

b) **in the event of a joint dislocation:**
- the X-ray or any other scan produced by medical imaging (e.g.: CT) confirming the abnormal position (dislocation) of bones.

c) **in the event of ligament rupture:**
- ultrasound, MR scan findings, if available,
- the hospital discharge summary if a surgery was performed, specifying the surgical procedure performed, its date and its description (operative report),
- in the case of plaster or rigid fixation, the medical document from the removal of the plaster/rigid fixation,

d) **in the event of a muscle or tendon rupture:**
- the hospital discharge summary if a surgery was performed, specifying the surgical procedure performed, its date and its description (operative report).

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for soft tissue injuries in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related expense reimbursement and damage to baggage and clothing (KBKTS/02026)

These special conditions apply to the **accident expense reimbursement insurance risk under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

Matters not regulated by these Special Conditions shall be governed by the **General Conditions of Pajzs Group Insurance** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. The insured event is **an accident** (Clause IX.1 of the general conditions) which occurs while the insurance policy is in force, 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 supported by invoices issued in Hungary:**

a) **rescue costs** necessarily incurred if 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) **transportation costs** incurred if the insured who has suffered an accident is transported from the scene of the accident to the nearest hospital or physician suitable for treatment, or, on one occasion, is transported home from the healthcare provider on medical advice, or if the insured dies as a result of the accident and their body is transported from the scene of the accident; the insurance company shall not provide any benefit for transporting the insured for dressing changes, suture removal or other medical examinations,

c) the repair costs of **teeth, dentures, crowns, bridges and other dental appliances injured or damaged in the accident,** except for removable dentures, provided that the damage is proven to be the result of the accident. Accident expenses do not include expenses incurred for repairing a pre-existing defect in a tooth, false tooth, crown, bridge or other dental aid that already existed before the accident, or the cost of repairing or replacing the insured's removable dentures.

d) the cost of purchasing **durable medical equipment** or other supplies necessary for treatment, such as dressings or medication, in the necessary quantity. Accident expenses do not include the cost of purchasing durable medical equipment if it is not in direct causal connection with the accident (for example, if existing durable medical equipment is repurchased because it is stolen, defective or replaced for quality reasons). 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.

e) the costs of physiotherapy, physical therapy, and balneotherapy required as a result of an accident, as well as the costs of outpatient medical examinations, treatments and diagnostic tests **not covered under the Hungarian Social Insurance System**.

I.3. An insured event also means an **accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person suffers an injury requiring medical care with a recovery period exceeding 8 days**, and the accident causes **damage to the insured person's clothing or baggage**.

I.4. Accident expenses shall not include travel and accommodation costs related to bath therapies and vacations.

I.5. The date of the insured event is the **date of the accident.**

II. INSURANCE CLAIMS AND LIMITATIONS TO CLAIMS PAYMENT

II.1. The insurance company shall reimburse the accident expenses, within the meaning of Clause I.2 of these special conditions, up to the sum insured stated in respect of this insured risk in the policy document effective as of the date of the accident -or if the insurance policy had been terminated, in the last effective policy document -or in the indexation letter, also subject to the limitations set out in Clause II.2 and Clause II.3 of these special conditions, in accordance with the following:

a) expenses incurred within two (2) years after the date of the accident, in respect of points a)-d) of Clause I.2 of these special conditions,

b) expenses incurred within 1 year of the date of the accident in the cases specified in Clauses I.2(e) and I.3 of these special conditions, provided that such expenses are not reimbursed in any other way.

II.2. In respect of any one accident, the insurance company's **reimbursement of the insured's accident expenses,** within the meaning of Clause I.2. e) of these special conditions, **shall be limited to maximum 50% of the sum insured stated in the policy document effective in respect of this risk as of the date of the accident – or if the insurance policy was terminated, in the last effective policy document – or in the indexation letter.**

II.3. The insurance company shall reimburse, up to half of the sum insured specified in respect of this cover in the policy document or indexation letter in force on the date of the insured event, the costs specified in Clause I.3 of these Special Conditions, provided that they are not reimbursed otherwise:

a) the costs of repairing or cleaning clothing or baggage damaged in the accident, or the value of the damaged clothing or baggage at the time of the accident if, as a result of the accident, it was damaged to such an extent that restoration is not possible;

b) the costs of replacing documents damaged in the accident;

c) spectacles or a wristwatch damaged in the accident, up to a maximum value of HUF 20,000.

As a result of the same insured event, the insurance company pays the beneficiary **no more than the sum insured specified in the policy document or indexation letter in force at the time of the insured event - or, after termination of the policy, in the last policy document or indexation letter in force.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

III.3.1. A **duly completed standard insurance claim form** made available by the insurance company,

III.3.2. the **invoices** issued to the name of the insured, certifying payments, **accompanied by the related medical documentation (outpatient records, etc.)**,

III.3.3. **as well as copies of the following documents:**

a) all medical documents related to the insured event from its occurrence until the notification of the insurance claim;
b) the accident report / the workplace accident report, if one was prepared,
c) the blood alcohol and/or psychoactive substance test result, if one was performed,
d) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,
e) other documents required to clarify the circumstances of the accident.

III.4. When assessing the claim, the insurance company may request presentation of the damaged or repaired item or garment.

III.5. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.6. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

IV.1. For this insurance, the insurance company shall be released from its obligation to pay the benefit for accident-related expenses in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

IV.2. In the case of this insurance, insurance cover shall also not extend to:

a) jewellery and precious metals;
b) works of fine art and collections;
c) cash or cash-equivalent payment instruments, banknotes, cheques, savings passbooks and other securities;
d) musical instruments;
e) valuable furs;
f) spectacles;
g) vehicle accessories and parts, and tools;
h) travel tickets and admission tickets;
i) sports equipment;
j) technical devices and their accessories;
k) items with an individual value exceeding HUF 100,000 at the time of acquisition, and their accessories.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related daily hospital benefit (KBKNT/02026)

These special conditions apply to **the accident-related daily hospital benefit insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means an **accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person receives inpatient hospital treatment** (Clause IX.2 of the general conditions), provided that such care is medically necessary.

I.2. For the purposes of this insurance, the person **receives inpatient hospital treatment** if such person is admitted to and stays in a hospital for multiple (more than one) days to receive medical care, and **spends every night of his/her hospitalization between the day of admission and the day of discharge in such institution in connection with the medical treatment.** Hospital admission is for more than one day if discharge from hospital occurs on a day later than the day of hospital admission. In the case of inpatient hospital treatment, for the purposes of the insurance benefit under Clause II of these special conditions, the first day of hospital care shall be the date of hospital admission and the last day of hospital care shall be the date of discharge from hospital.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. The insurance company shall pay the benefit for **inpatient hospital treatment** that is necessary to treat the consequences of the accident and is **provided within two years of the date of the accident**, **for the days of care provided** (Clause I.2 of these special conditions).

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

Where the insured person receives inpatient hospital treatment **after termination of the insurance policy due to an accident occurring during the period of insurance cover, the sum insured recorded for this insurance risk in the last policy document or indexation letter in force shall be taken into account** when determining the amount of the benefit.

II.3. If the insured receives inpatient hospital treatment in an intensive care unit of the relevant hospital, **the insurance company shall pay 200% of the sum insured determined under Clauses II.2 and II.4 of these special conditions for the days of care provided in the intensive care unit.**

For the purposes of these policy conditions an ‘intensive care unit’ (ICU) is a special hospital department which is authorized to provide intensive treatment medicine as labelled by its name, or referred to by its operations and operating licence.

For the purposes of these policy conditions, treatment provided in a subintensive care unit (SICU) or in a post-anesthesia care unit (PACU) does not qualify as treatment in an intensive care unit (ICU).

II.4. If the policy anniversary falls within a period during which the insured received inpatient hospital treatment and the **insurance policy is subject to indexation** (Clause IV.7 of the general conditions), the insurance company shall, from the policy anniversary, **take into account the increased sum insured** resulting from indexation when calculating the benefit in respect of the inpatient care and the days of hospitalization.

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies 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 issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
d) the accident report / workplace accident report, if one was prepared,
e) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
f) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,

– if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.4. **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 reject the insurance claim on the basis of the findings of such review.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the daily benefit for accident-related in-hospital treatment in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related surgical benefit (KBMÜT/02026)

These special conditions apply to the **accident-related surgical benefit insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means **an accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person requires surgery** (Clause IX.2 of the general conditions), provided that the surgery is medically necessary.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. If the insured is injured in an accident, the insurance pays a benefit for 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 insurance benefit is **the given percentage of the sum insured stated in respect of this risk in the policy document** effective as of the date of the surgery **– or if the insurance policy was already terminated, in the last effective policy document – or in the indexation letter, depending on the surgery performed.**

If the surgery is performed **after the termination of this insurance policy but within two years after the date of the accident referred to as the insured event,** the insurance benefit payout will be based on **the sum insured stated in respect of this risk in the last effective policy document, or in the indexation letter.**

II.3. The classification of **surgical procedures** into groups is set out in the **Surgical list**, which is included in Annex "B" to the general conditions. The **Surgical list** classifies surgical groups by benefit category. **The Surgical list also specifies the applicable benefit percentage.**

II.4. **If more than one surgeries are performed** on the same day or during the same procedure, the insurance company shall **determine the benefit on the basis of** the surgery with the lowest category number (**that is with the highest percentage of benefit payment**).

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the hospital discharge summary,
b) the surgical documentation, if any was made,
c) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
d) the accident/workplace accident report, if one was prepared,
e) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
f) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.4. **The insurance company is entitled to have the medical necessity of the surgery and the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for an accident-related surgery in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related burn injury (KBÉGS/02026)

These special conditions apply to the **accident-related burn injury insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means an accident (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person suffers a burn injury**.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. **The insurance company shall pay the % of the sum insured stated in respect of this risk in the policy document** effective as of the date of the insured event - **or if the insurance policy was already terminated, in the last policy document in force - or in the indexation letter, corresponding to the severity of the burns.**

II.2. **The amount of the benefit shall be the percentage of the sum insured shown in the table, depending on the degree and extent of the burn injury:**

Depth	Body surface area			
	10–19%	20–49%	50–79%	80% and over
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. Where it is duly evidenced that, directly as a consequence of the burn injury, the insured person has suffered at least third-degree burns to the head — meaning the facial skull and/or cranial skull, including the ear and the submental region of the neck — covering a total area of at least 2% of the total body surface area, the insurance company shall pay to the entitled person 200% of the sum insured recorded for this insurance risk **in the policy document or indexation letter in force at the date of the insured event** or, after termination of the policy, in the last policy document or indexation letter in force.

II.5. Where it is **duly evidenced that the insured person dies directly as a consequence of the burn injuries**, the insurance company shall pay **a benefit of 200% to the beneficiary in the event of death**, irrespective of the severity of the burn injury.

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the hospital discharge summary and outpatient report, if the insured person received hospital inpatient treatment or outpatient care as a consequence of the burn injury,
b) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
c) the accident/workplace accident report, if one was prepared,
d) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
e) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.3.3. **in the event of death**, copies of the following documents must also be submitted when notifying the benefit claim:
a) the relative's copy of the death investigation certificate/death case summary,
b) the insured's certificate of death,
c) **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.
d) other documents relating to the detailed circumstances of the death or the accident.

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for accident-related burn injuries in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for death caused by a traffic accident (KKHAT/02026)

These special conditions apply to the **traffic accident-related death insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means a **traffic accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person dies within one year following the accident.**

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. **If the insured dies as a result of a traffic accident occurring during the period of insurance cover** and the legal basis of the claim exists, **the insurance company shall pay to the beneficiary entitled to the death benefit the sum insured specified for this insurance risk in the policy document or indexation letter** in force at the time of death.

II.2. **If the insured dies after the termination of this insurance policy as a result of a traffic accident** which occurred while the insurance policy was in force**, but the insured person's death is** within one year after the date of the traffic accident specified as the insured event, the insurance benefit payout will be determined on the basis of **the sum insured specified in respect of this covered risk on the last policy document in force, or in the indexation letter.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the relative's copy of the death investigation certificate/death case summary,
b) the autopsy report, if one was prepared,
c) the insured's certificate of death,
d) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
e) the official on-site report of the passenger carrier company, the police report, or the workplace accident report, if one was made,
f) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
g) if the insured person **was injured or died as the driver of a vehicle**, the vehicle registration certificate,
h) the **document evidencing entitlement as beneficiary**, such as a final probate order or certificate of inheritance, provided that the beneficiary was not named in the policy.

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for death caused by a traffic accident in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for traffic accident-related permanent health impairment (KKROK/02026)

These special conditions apply to the **insurance cover for traffic accident-related permanent health impairment under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means a **traffic accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person suffers permanent health impairment.**

I.2. **Health impairment means a reduction in physical and/or mental functional capacity that restricts the insured person's normal way of life.**

I.3. **Health impairment shall be considered permanent if it can be regarded as medically established and stable.** Where the degree of health impairment **continues to change**, but **two years have elapsed from the date of the accident**, **after that two-year period the insurance company's medical expert shall determine the degree of demonstrably existing health impairment**, which the insurance company shall regard, for the purposes of its benefit payment obligation and the amount of the benefit, as **permanent health impairment** resulting from the accident. **Any change in working capacity and/or any forced discontinuation of sports activity shall not be relevant when determining permanent health impairment.** Adverse aesthetic consequences and other disadvantages, **including social or financial disadvantages**, resulting from the accident **shall not, in themselves, constitute grounds for a benefit claim** for permanent health impairment.

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. The insurance company shall **pay a benefit only if permanent health impairment exists** (Clause I.3 of these special conditions).

II.2. **If an insured event occurs, the insurance company shall pay a percentage of the sum insured stated in respect of this covered risk in the policy document in force at the time when the degree of permanent health impairment is established – or if the insurance policy was already terminated, in the last effective policy document – or in the indexation letter, corresponding to the extent of the permanent health impairment,** subject to Clause II.9 of these special conditions.

II.3. **The degree of permanent health impairment** on which the benefit is based **shall be determined by the insurance company's physician with reference to the table in Annex "A", which forms an integral part of the general conditions applicable to the policy.**

II.4. If the **degree of health impairment cannot be determined on the basis of the table**, the benefit shall be determined **on the basis of the medically assessed reduction in physical and/or mental integrity**.

Organs or body parts that were already permanently impaired and not intact before the accident shall be excluded from insurance cover up to the degree of the pre-existing impairment.

The degree of disability or health impairment determined in the expert opinion of the **Medical Expert Institute** (the body authorised under Hungarian legislation in force from time to time to determine the degree of health impairment/state of health) or **in the decision of the pension insurance administrative body** shall not be determinative for the degree of permanent health impairment to be established by the insurance company's physician or for determining the benefit amount payable by the insurance company. **The insurance company shall not be bound by any decision or expert opinion of another medical expert body when determining the permanent nature of health impairment or the degree of permanent health impairment.**

II.5. **Permanent health impairment** established as the consequence of a single insured event **may not exceed 100%**.

II.6. **If the insured dies before the health impairment becomes final, the benefit is payable for the degree of health impairment that the insurance company's physician determines can be taken into account on the basis of the documents of the most recent medical examination.**

II.7. **No benefit claim** for permanent health impairment **may be made if the insured person dies within 15 days after the accident.**

II.8. **If the insurance company has already established its benefit payment obligation but the amount payable** as a benefit **cannot yet be determined, the insured person may require the insurance company to pay the minimum amount due to the insured person** on the basis of the facts of the case.

II.9. **Where, following payment** by the insurance company**, the insured person's state of health continues to deteriorate as a consequence of the same insured event on the basis of which the insurance company has already paid a benefit, the insured person may, by submitting medical documents evidencing deterioration** despite appropriate medical treatment, **submit a repeated benefit claim once per year per insured event,** for no more than four years from the date of the reported accident, **requesting a review of their state of health and a renewed determination of the degree of permanent health impairment.** Where deterioration is established by the insurance company's physician, the insurance company shall pay the benefit on the basis of the sum insured recorded in the policy document or indexation letter in force at the time of the review, **deducting from the subsequent benefit payable any amounts previously paid in**

connection with the above insured event.

Even in this case, the degree of permanent health impairment established as a consequence of the same insured event **may not exceed 100%.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
b) the police report, if one was prepared,
c) the official on-site report of the passenger carrier company, the police report, or the workplace accident report, if one was made,
d) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
e) if the insured person **was injured as the driver of a vehicle**, the vehicle registration certificate,
f) other documents required to clarify the circumstances of the accident.

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

III.6. **Where the legal basis of the claim has been acknowledged, the insurance company shall pay the benefit within the following time limits:**

a) the benefit determined **on the basis of medically clearly established permanent health impairment**: **within 15 days after receipt of the last document** required to assess the benefit claim;
b) in other cases, **within 15 days after the impairment becomes definitive, but no later than within 15 days after the expiry of four years following the accident.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for traffic accident-related permanent health impairment in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for accident-related incapacity for work (KBKEK/02026)

These special conditions apply to the **accident-related incapacity for work insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. CONDITIONS FOR TAKING OUT INSURANCE COVER FOR ACCIDENT-RELATED INCAPACITY FOR WORK

I.1. Under these special conditions, **insurance cover for accident-related incapacity for work may not be taken out for any person who is not entitled** in their own right **to sickness benefit** under the compulsory health insurance system.

I.2. **The policyholder/insured person shall notify** the insurance company in writing **within 15 days** if their **entitlement to sickness benefit** under the compulsory health insurance system **ceases during the period of insurance**. In this case, the part of the policy that contains insurance cover for accident-related incapacity for work shall terminate in respect of the insured person on the first day of the month following the cessation of entitlement to sickness benefit.

I.3. If, in respect of the given insured person, the part of the policy containing insurance cover for accident-related incapacity for work has terminated pursuant to Clause I.2, insurance cover for this risk may be reinstated, after the reason for termination has ceased to exist, with the insurance company's consent, on the basis of the written request of the policyholder and the insured person and the medical risk assessment carried out by the insurance company.

II. INSURED EVENT

II.1. An insured event means an **accident** (Clause IX.1 of the general conditions) occurring during the period of insurance cover **as a result of which the insured person is certified**, in accordance with applicable legislation by a physician authorized to assess and certify incapacity for work, **as being incapacitated for work in their own right and receives sickness benefit in Hungary**.

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

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

III.1. The insurance company shall **pay the benefit for days of incapacity for work occurring within two years from the date of the accident where such incapacity** is necessary **to address the consequences of the accident.**

III.2. **The insurance will not cover** the **first specified number of days** of **continuous incapacity** (hereinafter: elimination period) **as stated in** the insurance policy (insurance application).

III.3. **The amount of the benefit** is determined **by multiplying the sum insured fixed in respect of this cover in the policy document or index letter in force at the time when the insured becomes incapacitated for work, by the number of days on which the insured was considered incapable of work under these special conditions, taking into account the elimination period.**

III.4. **If the insured person's incapacity for work occurs after the termination of this insurance policy but within two years of the date of the accident** during the cover period**,** the amount of the benefit payable under this cover will be determined based on **the sum insured stated in respect of this cover in the last policy document or in the last indexation letter.**

III.5. If the policy anniversary falls within a period when the insured is certifiably incapacitated within the meaning set out herein, and the **insurance policy is taken out with annual indexation** (Clause IV.7. of the general conditions), the insurance company shall pay to the insured an increased benefit set out in the indexation letter in respect of this insurance cover from the anniversary date of the insurance.

III.6. **For the same accident** – if the claim is grounded – **the insurance pays benefits for a maximum of 150 days, within two years of the date of the accident.**

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. **The insurance claim must be notified to the insurance company at the latest 15 days after the end of the elimination period for the first time, and at least every 14 days thereafter.**

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) the form issued by the physician authorised to determine incapacity for work, prescribed under applicable legislation for certifying incapacity for work ("Medical certificate of placement on incapacity-for-work [pregnancy-related] sick leave"), and a certificate from the attending physician specifying the reason for the incapacity for work/the exact diagnosis,

b) where hospital treatment was also provided: the hospital discharge summary, within 15 days after completion of the hospital treatment,

c) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
d) the accident/workplace accident report, if one was prepared,
e) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
f) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

IV.3.3. **in the case of continuous incapacity for work:**
a) the documents specified in Clauses IV.3.1 and IV.3.2 d), e) and f) need only be submitted upon the first notification,
b) a copy of the medical certificate of continuous incapacity for work issued by the physician authorised to assess incapacity for work in accordance with applicable legislation must be submitted to the insurance company within 14 days of its issue, quoting the policy number ("Medical certificate of continuous incapacity for work"),
c) in addition, the insured person must submit new documents from the attending physician describing their state of health to the insurance company every 60 days,
d) the certificate from the attending physician specifying the reason for the incapacity for work/the exact diagnosis.

IV.4. **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 reject the insurance claim on the basis of the findings of such review.**

IV.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

V.1. For this insurance, the insurance company shall be released from its obligation to pay the benefit for the insured's accident-related incapacity in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

V.2. In addition to the cases specified in the general conditions, insurance cover shall not extend to any period of incapacity for work during which the insured person carries out gainful activity.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for daily hospital benefit (KEKNT/02026)

These special conditions apply to **the daily hospital benefit insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. **An insured event means an unexpected illness or accident** (Clauses IX.1 and IX.2 of the general conditions) **with no antecedent condition at the commencement of insurance cover, as a result of which the insured person receives inpatient hospital treatment** (Clause IX.2 of the general conditions), provided that such treatment is medically necessary.

I.2. For the purposes of this insurance, a person receives **inpatient hospital treatment** if they are admitted to hospital for more than one day in order to receive medical care and **spend every night between the date of hospital admission and the date of discharge in hospital in connection with that medical care**. Hospital admission is for more than one day if discharge from hospital occurs on a day later than the day of hospital admission. In the case of inpatient hospital treatment, for the purposes of the insurance benefit under Clause II of these special conditions, the first day of hospital care shall be the date of hospital admission and the last day of hospital care shall be the date of discharge from hospital.

I.3. The **date of the insured event** shall be the **first day of hospital treatment** in the case of the **insured person's illness-related inpatient hospital treatment**, and the **date of the accident** in the case of the **insured person's accident-related inpatient hospital treatment**.

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. In the event of the **insured's illness**, the insurance company shall pay the insurance benefit for **each day** (Clause I.2. of these special conditions) **of the insured's inpatient hospital treatment while the insurance policy is in force**. **Where the insured person suffers an accident** during the period of insurance cover, **the insurance company shall pay the benefit** for the days of inpatient hospital treatment (Clause I.2 of these special conditions) **that become necessary within two years from the date of the accident in order to address the consequences of the accident.**

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

Where the insured person receives inpatient hospital treatment after termination of the insurance policy **due to an accident occurring** during the period of insurance cover**, the sum insured recorded for this insurance risk in the last policy document or indexation letter in force shall be taken into account when determining the amount of the benefit.**

II.3. If the insured receives inpatient hospital treatment in an intensive care unit of the relevant hospital, **the insurance company shall pay 200% of the sum insured determined under Clauses II.2 and II.4 of these special conditions for the days of care provided in the intensive care unit.**

For the purposes of these policy conditions an 'intensive care unit' (ICU) is a special hospital department which is authorized to provide intensive treatment medicine as labelled by its name, or referred to by its operations and operating licence.

For the purposes of these policy conditions, treatment provided in a subintensive care unit (SICU) or in a post-anesthesia care unit (PACU) does not qualify as treatment in an intensive care unit (ICU).

II.4. If the policy anniversary falls within a period during which the insured received inpatient hospital treatment and the **insurance policy is subject to indexation** (Clause IV.7 of the general conditions), the insurance company shall, from the policy anniversary, **take into account the increased sum insured** resulting from indexation when calculating the benefit in respect of the inpatient care and the days of hospitalization.

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

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies 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 case of **accident-related inpatient hospital treatment**, also:
   – all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   – the accident report / workplace accident report, if one was prepared,
   – the result of any blood alcohol and/or narcotic substance test, if such test was performed,

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

III.4. **The insurance company is entitled to have the medical necessity of the medical treatment and medical care, and the insured person's state of health, examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the daily benefit for in-hospital treatment in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for surgical benefit (KEMÜT/02026)

These special conditions apply to the **surgical benefit insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

In matters not regulated in these special conditions, the **general terms and conditions of Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy has been concluded, **shall apply**.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. **An insured event means an unexpected illness or accident** (Clauses IX.1 and IX.2 of the general conditions) **with no antecedent condition at the commencement of insurance cover**, **as a result of which the insured person requires surgery** (Clause IX.2 of the general conditions), provided that the surgery is medically necessary.

I.2. **The date of the insured event shall be the date on which the surgery is performed in the case of the insured person's illness-related surgery, and the date of the accident in the case of the insured person's accident-related surgery.**

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. **In the event of the insured's illness**, **the insurance company shall provide the benefit for surgeries performed during the period of insurance cover** and, **in the event of the insured's accident, for surgeries performed within two years of the date of the accident** that are necessary to treat the consequences of the accident.

II.2. The insurance benefit is **the given percentage of the sum insured stated in respect of this risk in the policy document** effective as of the date of the surgery **– or if the insurance policy was already terminated, in the last effective policy document – or in the indexation letter, depending on the surgery performed.**

II.3. If the surgery **– required as a result of the insured person's accident –** is performed **after the termination of this insurance policy but within two years after the date of the accident referred to as the insured event,** the insurance benefit payout will be based on **the sum insured stated in respect of this risk in the last effective policy document, or in the indexation letter.**

II.4. The classification of **surgical procedures** into groups is set out in the **Surgical list**, which is included in Annex "B" to the general conditions. The **Surgical list** classifies surgical groups by benefit category. **The Surgical list also specifies the applicable benefit percentage.**

II.5. **If more than one surgeries are performed** on the same day or during the same procedure, the insurance company shall **determine the benefit on the basis of** the surgery with the lowest category number (**that is with the highest percentage of benefit payment**).

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the hospital discharge summary,
b) the surgical documentation, if any was made,
c) additionally, if the insured event is the result of an **accident**:
   - all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   - the accident report / workplace accident report, if one was prepared,
   - the blood alcohol and/or psychoactive substance test result,
d) in the case of a **traffic accident**, in addition to the above:
   - the police report, if one was prepared,
   - if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

III.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the surgical benefit in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for health impairment exceeding 69% (KEOEP/12026)

These conditions apply to the **insurance cover for health impairment exceeding 69% under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions **shall be governed by the general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

For the purposes of this condition, Medical Expert Institute means the authority defined under Hungarian legislation in force from time to time as being authorized to determine the degree of health impairment/state of health.

I. INSURED

Under these special conditions, **an individual may not be an insured person** if, **before conclusion of the policy (before signing the application),**

a) they already receive **pension benefits in their own right** or receive **any type of benefit or annuity**, for example disability or accident benefit, due to health impairment or reduction in working capacity established in an expert opinion by the Medical Expert Institute, or
b) they **have already submitted a request to the competent authority**, due to their state of health, for the determination or assessment of health impairment or reduction in working capacity.

II. INSURED EVENT

II.1. An insured event is the insured's **health impairment to an extent of over 69%** during the period of cover, as **determined by a medical expert opinion of the Institute of Medical Experts,** which results from an **unexpected illness or accident with no antecedent condition at the commencement of insurance cover**, provided that **the insured submits a claim for the assessment of his/her health impairment to the competent authority during the period of cover**.

II.2. **The date of the insured event shall be the date of the expert opinion of the Medical Expert Institute.**

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

III.1. If an insured event occurs, the insurance company shall pay the sum insured specified for this insurance risk in **the policy document or indexation letter in force on the date of the expert opinion of the Medical Expert Institute or, after termination of the policy, in the last policy document or indexation letter in force,** and the part of the policy that includes the insurance cover under these special conditions shall thereby terminate in respect of the insured concerned.

III.2. **Upon the occurrence of an insured event, the insurance premium payable in respect of the given insured person shall be due to the insurance company until the end of the insurance year in which the insured event occurred.**

III.3. If the policy includes a waiting period (Clause II.3.5 of the general conditions) and, **before the expiry of the waiting period**, the insured concerned suffers an **illness that is not causally related to an accident** and that serves as the basis for establishing health impairment exceeding 69%, **the insurance company shall refund to the policyholder the insurance premiums paid** for the insurance under these special conditions in respect of that insured.

Upon repayment of the premium, the part of the policy containing insurance cover under these special conditions **shall terminate** in respect of the given insured person **retroactively** to the commencement of insurance cover for this risk.

III.4. If the policy includes a waiting period (Clause II.3.5 of the general conditions) and the insured concerned **initiates** the assessment of their health impairment with the competent authority **during the waiting period**, the insurance company shall refund to the policyholder the insurance premiums paid for the insurance under these special conditions in respect of that insured, unless the claim is based on the consequence of a documented accident that occurred after the commencement of insurance cover. **Upon repayment of the premium**, the part of the policy containing insurance cover under these special conditions **shall terminate** in respect of the given insured person **retroactively** to the commencement of insurance cover for this risk.

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) **Expert opinion of the Medical Expert Institute;**
b) where the expert opinion of the Medical Expert Institute is dated after termination of the insurance cover, **proof of the date of submission of the request** for determining health impairment exceeding 69%,
c) the statement of the attending physician or general practitioner, naming the underlying illness(es) behind the insured event and specifying the exact date of first diagnosis and course of the illness(es),

d) where the health impairment exceeding 69% **is causally related to an accident**, also:
   - all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   - the accident report / workplace accident report, if one was prepared,

e) in the case of a **traffic accident**, in addition to the above:
   - the police report, if one was prepared,
   - if the insured **was injured in a traffic accident** as the **driver of a vehicle**, the insured's driving license and the vehicle registration certificate.

IV.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

IV.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit specified in these special conditions in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

VI. TERMINATION OF INSURANCE COVER UNDER THIS CONDITION

The part of the policy containing insurance cover under this special condition shall terminate in respect of the given insured person upon the occurrence of any of the following circumstances:

a) upon **payment of the benefit** by the insurance company under this special condition, or
b) if the insured person **becomes entitled to old-age pension**, or
c) if the **insured person reaches the old-age retirement age** applicable to them.

Where any of the circumstances listed in paragraphs b) and c) of this Clause occurs, **the policyholder shall notify the insurance company of this in writing within 15 days from the occurrence of the relevant circumstance.**

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for health impairment exceeding 39% (KEOEP/22026)

These conditions apply to the **insurance cover for health impairment exceeding 39% under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

For the purposes of this condition, Medical Expert Institute means the authority defined under Hungarian legislation in force from time to time as being authorised to determine the degree of health impairment/state of health.

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) already **receives pension benefits in their own right or any type of benefit or annuity**, for example disability or accident benefit or annuity, due to health impairment or reduction in working capacity established in an expert opinion by the Medical Expert Institute, or
b) has already **submitted a request to the competent authority**, due to their state of health, for the determination or assessment of health impairment or reduction in working capacity.

II. INSURED EVENT

II.1. An insured event means **health impairment exceeding 39%** in respect of the insured**, established by the expert opinion of the Medical Expert Institute during the period of insurance cover, which results from an unexpected illness or accident that** had no antecedent at the commencement of insurance cover, provided that **the insured submits their application for the assessment of the health impairment to the competent authority during the period of insurance cover and, according to the expert opinion of the Medical Expert Institute, the insured's rehabilitation is not recommended.**

II.2. **The date of the insured event shall be the date of the expert opinion of the Medical Expert Institute.**

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

III.1. If an insured event occurs, the insurance company shall pay the sum insured specified for this insurance risk in **the policy document or indexation letter in force on the date of the expert opinion of the Medical Expert Institute or, after termination of the policy, in the last policy document or indexation letter in force,** and the part of the policy that includes the insurance cover under these special conditions shall thereby terminate in respect of the insured concerned.

III.2. If the policy includes a waiting period (Clause II.3.5 of the general conditions) and, **before the expiry of the waiting period**, the insured concerned suffers an **illness that is not causally related to an accident** and that serves as the basis for establishing health impairment exceeding 39%, the **insurance company shall refund to the policyholder the insurance premiums paid** for the insurance under these special conditions in respect of that insured.

Upon repayment of the premium, the part of the policy containing insurance cover under these special conditions **shall terminate** in respect of the given insured person **retroactively** to the commencement of insurance cover for this risk.

III.3. If the policy includes a waiting period (Clause II.3.5 of the general conditions) and the insured concerned **initiates** the assessment of their health impairment with the competent authority **during the waiting period**, the insurance company shall refund to the policyholder the insurance premiums paid for the insurance under these special conditions in respect of that insured, unless the claim is based on the consequence of a documented accident that occurred after the commencement of insurance cover.

Upon repayment of the premium, the part of the policy containing insurance cover under these special conditions **shall terminate** in respect of the given insured person **retroactively** to the commencement of insurance cover for this risk.

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) **Expert opinion of the Medical Expert Institute;**
b) where the expert opinion of the Medical Expert Institute is dated after termination of the insurance cover, proof of the date of submission of the request for determining health impairment exceeding 39%,
c) the statement of the attending physician or general practitioner, naming the underlying illness(es) behind the insured event and specifying the exact date of first diagnosis and course of the illness(es),

d) where the health impairment exceeding 39% is **causally related to an accident**, also:
   - all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   - the accident/workplace accident report, if one was prepared,

e) in the case of a **traffic accident**, in addition to the above:
   - the police report, if one was prepared,
   - if the insured **was injured in a traffic accident** as the **driver of a vehicle**, the insured's driving license and the vehicle registration certificate.

IV.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

IV.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit specified in these special conditions in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

VI. TERMINATION OF INSURANCE COVER UNDER THIS CONDITION

The part of the policy containing insurance cover under this special condition shall terminate in respect of the given insured person upon the occurrence of any of the following circumstances:

a) upon **payment of the benefit** by the insurance company under this special condition, or
b) if the insured person **becomes entitled to old-age pension**, or
c) if the **insured person reaches the old-age retirement age** applicable to them.

Where any of the circumstances listed in paragraphs b) and c) of this Clause occurs, **the policyholder shall notify the insurance company of this in writing within 15 days from the occurrence of the relevant circumstance.**

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for 40 specified critical illnesses (KEDRD/02026)

These special conditions apply to the **part of the insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company) **that contains insurance cover for specified critical illnesses**, provided that the policy was concluded by reference to these conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded. In all other respects, the provisions of the Hungarian Civil Code and **other applicable Hungarian legislation** shall apply to the policies as appropriate.

For the purposes of this special condition, Medical Expert Institute means the authority defined under Hungarian legislation in force from time to time as being authorised to determine the degree of health impairment/state of health.

I. INSURED EVENT, DATE OF THE INSURED EVENT

I.1. An insured event means **any unexpected illness listed below** and defined in Clause I.2 which occurs during the period of insurance cover **and has no antecedent condition at the commencement of insurance cover, or any treatment or surgery that becomes necessary due to an unexpected underlying illness with no antecedent condition at the commencement of insurance cover.**

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) coronary sclerosis (coronaria sclerosis)
11) artificial heart implantation
12) heart valve surgery
13) cardiomyopathy
14) intracranial vascular surgery
15) open thoracic and/or abdominal aortic surgery
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) end-stage lung 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 inflammatory skin disease

I.2. For the purposes of these special conditions, the **medical conditions listed in Clause I.1. are defined as follows**:

1) **Myocardial infarction (heart attack)** means necrosis of part of the heart muscle caused by a sudden insufficiency in the blood supply to the affected area. For the purposes of these special conditions, only pathological conditions in which the extent of the affected area results in the development of an abnormal Q wave detectable using standard ECG recording techniques shall be considered myocardial infarction.

   The date of the insured event: the time of the onset of the illness, as determined by the attending physician.

2) In the case of **malignant neoplasms**, there is uncontrolled growth of cells showing signs of histological atypia (malignant cells), with the possibility of malignant cells spreading across tissue boundaries (invasion) and the potential for malignant cells to colonize, proliferate and invade distant organs (metastasis).

   Under these special conditions, the group of malignant diseases also includes malignant tumours of the haematopoietic tissues, meaning leukaemias, tumours originating from the reticuloendothelial and lymphatic systems, meaning lymphomas, and malignant plasma cell disorders, meaning plasma cell myeloma.

The insurance does not cover the following groups of malignant tumors:
- premalignant (precancerous) conditions,
- tumors that do not spread to the surrounding area (in situ),
- skin cancer, excluding malignant tumours of the pigmented moles (melanoma malignum),
- 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** is a pathological condition (rupture of the vascular wall, total or partial blockage of a vessel due to thrombosis or embolism) in the intracranial vessel, resulting in necrosis, infarction and permanent organ and nervous system damage (so-called focal neurological signs/symptoms) of the central nervous system areas supplied by the vessel, i.e. physical symptoms indicating damage are clearly detectable even 30 days after the onset of the vascular accident or 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 insurance company's physician-expert, or a specialist consultant appointed 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** is a condition where the function of both kidneys is irreversibly reduced and this reduction is such that the condition is incompatible with life without artificial kidney treatment or transplantation, and the insured requires dialysis treatment for at least 60 days from the start of dialysis.

   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** means an open-chest procedure intended to eliminate the narrowing or occlusion of two or more vessels confirmed by coronary angiography, by removing the diseased vessel segment and replacing it with a vessel taken from another part of the body, or by bypassing the diseased vessel segment with a healthy artery.

   The date of the insured event: the date of the surgery.

6) **Organ transplantation** means a surgical procedure in which a heart, heart-lung complex, lung, liver or kidney from another person's body (donor) is transplanted into the body of the person receiving the organ (recipient). **The term 'organ transplantation' does not include human cell and tissue transplantation. Therefore, the transplantation of pancreas, skin and bone, or blood transfusion is not an insured event.**

   The date of the insured event: the date of the surgery.

7) **AIDS** means a condition in which the number of CD4+ cells (lymphocytes) in the blood of an HIV-infected person remains persistently below 200/µl and an opportunistic infection occurs, caused by pathogens present in humans that are otherwise harmless.

   The date of the insured event: the date of the diagnosis of the disease.

8) **Benign tumour** is a brain or spinal cord tumour confirmed as benign by an advanced diagnostic method (CT/MR), which results in complete paralysis of one side of the body even after 6 months after the end of treatment.

   The date of the insured event: the date of the diagnostic procedure confirming the disease.

9) **Pacemaker-defibrillator implant** means the permanent pacemaker and defibrillator implantation surgery required due to conduction disturbance and ventricular fibrillation.

   The date of the insured event: the date of final pacemaker and defibrillator implant surgery.

10) **Coronary sclerosis** means narrowing of the coronary arteries affecting three vessels to such a degree that, as confirmed by cardiac catheterisation, revascularisation would be required, but according to the medical documentation the main coronary artery supplying the left ventricle, the LAD, is not suitable for any intervention or surgery.

    The date of the insured event: the date of the cardiac catheterization.

11) **Artificial heart implantation**
    Artificial heart surgery means a medical procedure in which an artificial heart is permanently implanted in the patient's body to replace permanently impaired cardiac function, and the artificial heart is performing its function 30 days after the surgery. An external cardiac motor used during surgical procedures or a temporary intra-aortic cardiac pump treatment is not considered an artificial heart.

    The date of the insured event: the date of the surgery.

12) **Cardiac valve surgery** is defined as cardiac surgery with extracorporal ("heart motor") circulatory maintenance involving opening of the chest, valve replacement and/or valve plastic surgery, after which the insured person is under cardiological control beyond the 30th day following the operation.

    The date of the insured event: the date of the surgery.

13) **Cardiomyopathy** means a myocardial disease in which cardiac performance (EF), despite treatment, continuously does not exceed 20% for at least six months.
    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) **Intracranial vascular surgery** means surgery on a cerebral or meningeal blood vessel, necessitated by disease and involving opening of the cranium. Surgery necessitated by an accident or performed solely to reduce intracranial pressure shall not be considered an insured event.

    The date of the insured event: the date of the surgery.

15) **Open thoracic aortic and/or abdominal aortic surgery** is defined as a surgery involving the opening of the chest and/or abdominal cavity due to an illness. Surgery necessitated by an accident is not an insured event.

The date of the insured event: the date of the surgery.

16) **Aortobifemoral bypass surgery** means bypass surgery performed on both femoral arteries in a single procedure due to arterial stenosis. Surgery due to femoral artery stenosis caused by atherosclerosis diagnosed within 6 months after the commencement of cover, or an operation performed using a vascular catheter technique, is not considered an insured event.

The date of the insured event: the date of the surgery.

17) **Alzheimer's disease** means a neurological illness of such severity that it is characterised by the gradual deterioration of mental capacity, behavioural disturbance and biological deterioration following the development of dementia, and the expert opinion of the Medical Expert Institute establishes health impairment exceeding 49% solely due to this illness.

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

18) **Parkinson's disease** means a progressive neurological disease of such severity that it is characterised by involuntary movements manifested in tremor, muscle rigidity, slowness of movement and balance disorder, and the expert opinion of the Medical Expert Institute establishes health impairment exceeding 49% solely due to this disease.

The insurance does not cover a disease diagnosed as Parkinson's syndrome (caused by e.g. medication, toxic injuries, or arteriosclerosis).

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

19) **Multiple sclerosis** means a demyelinating illness of such severity, causing progressive neurological and psychological symptoms, as a consequence of which the expert opinion of the Medical Expert Institute establishes health impairment exceeding 49% solely due to this illness.

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

20) **Loss of hearing** means hearing loss in both ears resulting from illness or accident, which is permanent, cannot be corrected by surgery or by an assistive device, has persisted continuously for at least six months, and is at least 91 dB in each ear.

Date of the insured event: the date of the ear, nose and throat specialist's examination document establishing the loss of hearing in both ears, stating that the condition is definitive, and recording the audiogram test result.

21) **Loss of vision** occurs where, as a result of illness or accident, the vision in both eyes has deteriorated irreversibly for at least 6 months, cannot be improved by correction, and has deteriorated to such an extent that, due to loss of visual field, the remaining visual field does not reach 10% in either eye, and/or, as a result of the deterioration in visual acuity, both eyes are only capable of perceiving hand movement, or, as a combined result of the loss of visual field and the deterioration in visual acuity, the reduction in visual acuity (LÉCS) is 100%, and the expert opinion of the Medical Expert Institute confirms the foregoing.

The date of the insured event: the date of the ophthalmological examination document confirming the insured event and describing the condition as definitive.

22) **Loss of speech** occurs when the previously intact speech ability is completely and permanently impaired, beyond the correctable range of assistive devices, to the extent that for at least 6 months, the lack of volume and articulation necessary for communication has prevented the pronunciation of meaningful words, as confirmed by a medical opinion from the Medical Expert Institute. It shall not be deemed as an insured event if loss of speech occurs due to a psychiatric reason.

Date of the insured event: the date of the expert opinion of the Medical Expert Institute.

23) **Aplastic anaemia** occurs if the disease is confirmed by haematological opinion based on bone marrow examination and the treatment has been continuous for at least 1 year with at least 4 units of transfusion (blood replacement) per month. 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 where continuous factor replacement has been required for at least one year due to haemophilia and the deficient blood clotting factor is below 1% of the physiological level. Factor replacement required because of any procedure or surgery involving a risk of bleeding, or because of another disease, or factor replacement that is not administered continuously, shall not constitute an insured event.

The date of the insured event: the date of the first factor replacement administered in accordance with 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** shall be considered an insured event if, after completion of antiviral or other curative treatment, the documentation of the hepatology institute providing the treatment confirms that Hepatitis C virus infection remains present, together with liver cirrhosis due to liver damage, associated with oesophageal varices and abnormal liver function test results, and no further causal treatment is possible.

The date of the insured event: the date of the medical specialist examination document of hepatology supporting the insured event.

27) **Severe burns** occur when heat causes third-degree burns affecting at least 20% of the total body surface, and the insured requires medical treatment for more than 30 days after the date of the 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 considered an insured event if the disease results in the removal of the entire colon and the concomitant development of a permanent ileostoma.

The date of the insured event: the date of the surgery.

30) **Crohn's disease** is considered an insured event if a surgical removal of a bowel segment has taken place 3 times during the course of the disease, or a permanent stoma has been created (closure of the anus and removal of the rectum).

The date of the insured event: the date of the 3rd surgery/of final stoma preparation.

31) **Small intestine surgery** shall qualify as an insured event if, for any reason, at least half of the small intestine has been removed, as supported by the operative report and histological findings.

The date of the insured event: the date of the surgery.

32) **Nephrostomy surgery** is considered an insured event if a definitive 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) **End-stage lung disease** shall be considered an insured event if, solely as a result of this disease, the expert opinion of the Medical Expert Institute establishes health impairment exceeding 79%.

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

34) **Rheumatoid arthritis (RA)** shall be considered an insured event if, solely as a result of this polyarticular disease, the expert opinion of the Medical Expert Institute establishes health impairment exceeding 69%..

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

35) **Ankylosing spondylitis (Bekhterev's disease)** shall be considered an insured event if, solely as a result of this spinal disease, the expert opinion of the Medical Expert Institute establishes health impairment exceeding 69%.

The date of the insured event: The issue date of the expert opinion of the Medical Expert Institute.

36) **Amputation** means the amputation of two or more limbs during the policy period, for any reason other than 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 where paralysis of the nervus facialis, or facial nerve, is so severe that feeding is impossible due to impaired mouth closure and, for that reason, feeding has been provided continuously for at least 6 months through a gastric or small-intestinal feeding tube inserted through the abdominal wall.

The date of the insured event: the date of implantation of the stomach or small intestine tube.

38) **Oesophageal stricture** occurs where narrowing of the oesophagus due to a non-malignant disease is so severe that feeding has been provided continuously for at least six months through a gastric or small-intestinal feeding tube surgically inserted through the abdominal wall.

The date of the insured event: the date of insertion of the gastric or small-intestinal feeding tube.

39) **Constrictive pericarditis** is deemed to be an insured event if open thoracic pericardial surgery has been performed for treatment.

The date of the insured event: the date of the surgery.

40) **Chronic acquired inflammatory skin disease**, such as allergic or irritant contact dermatitis, atopic dermatitis or psoriasis, shall be considered an insured event if, despite treatment directed by a dermatologist, the inflammation has been continuously present in an active stage for at least one year at the time of notification of the claim, affecting at least 50% of the body surface area, including both palms and both soles.

The date of the insured event: the date of the diagnosis of the disease.

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. If an insured event occurs, **the insurance company will pay the sum insured stated in the policy document effective as of the date of the insured event** or – if the insurance policy was already terminated, – in the last effective policy document **or in the indexation letter, and the part of the insurance policy relating to the critical illness cover will be terminated.**

II.2. **If the insured event occurs in causal connection with any of the events listed in Clause I.1 of these special conditions, but the benefit** under Clause II.1 of these special conditions **was not paid by the insurance company during the insured person's lifetime,** the insurance company shall pay **the sum insured recorded for this insurance risk in the policy document or indexation letter in force at the time of death to the beneficiary entitled to the death benefit.**

II.3. Under these special conditions, **the insurance company shall pay the benefit corresponding to the sum insured no more than once for the same insured person, even if several of the illnesses referred to** in Clause I.1 of these special conditions **occur concurrently or separately in respect of that insured person.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The insurance claim shall be notified to the insurance company **within 15 days** after the occurrence of the insured event.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**
a) the hospital discharge summary,
b) if a surgery was performed, the operative report, if one was made.

III.3.3. **and the documents specified below:**
1. **in the case of myocardial infarction**
   a) ECG change indicative of recent myocardial infarction (for the purposes of these special conditions, only myocardial infarctions in which, in causal connection with coronary artery occlusion, a pathological Q wave not previously detected is present in any lead of a standard 12-lead ECG — with a duration exceeding 40 ms and an amplitude equal to 25% of the R-wave amplitude — shall be considered to fall within the scope of insurance cover), and
   b) a pathological increase in so-called myocardial-specific enzyme levels – a significant, well-documented increase in the levels of any intracellular enzyme (CPK, CKMB, SGOT, LDH, alpha-HBDH) should be considered as a fulfilment of this condition.
2. **In the case of a malignant tumor**
   a copy of the positive histological confirmation (describing the malignant nature of cells and their invasive growth).
3. **in the case of a cerebrovascular accident**
   copies of the medical documents evidencing symptoms indicating organic central nervous system damage that are still present 30 days after the vascular event, are causally related to that vascular event, and the vascular event is substantiated by an authentic document.
4. **in the case of 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 institution that performed the dialysis.
5. **in the case of a coronary artery surgery**
   a copy of the discharge summary confirming that the bypass surgery was performed on the basis of a properly established medical recommendation based on the abnormalities shown by the prior coronary angiography.
6. **in the case of 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. **In the case of 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. **in the case of 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 completion.
9. **In the case of a pacemaker-defibrillator implant surgery**
   all documents produced in relation to the cardiovascular disease,
10. **In the case of coronary sclerosis**
    a) all documents produced in relation to the cardiovascular disease,
    b) documentation of cardiac catheterization.
11. **In the case of artificial heart implantation**
    a) all documents produced in relation to the cardiovascular disease,
    b) the hospital discharge summary of the artificial heart implantation, and
    c) results of the cardiology control check performed at least 30 days after the surgery.
12. **In the case of a heart valve surgery**
    a) all documents produced in relation to the cardiovascular disease,
    b) the hospital discharge summary confirming the open thoracic surgery,
    c) results of the cardiology control check performed at least 30 days after the surgery.
13. **In the case of cardiomyopathy**
    the complete cardiological documentation, including documents on the 6 months preceding the notification of the claim for benefit.
14. **in the case of intracranial vascular surgery**
    all medical documents produced in relation to the illness which required the undergoing of surgery.
15. **In the case of an open thoracic and/or abdominal aortic surgery**
    all medical documents produced in relation to the illness which required the undergoing of surgery.
16. **in the case of an aortobifemoral bypass surgery**
    all medical documents produced in relation to the illness which required the undergoing of surgery.
17. **in the case of Alzheimer's disease (AD)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the Medical Expert Institute.
18. **in the case of Parkinson's disease (PD)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the Medical Expert Institute.
19. **in the case of Multiple sclerosis (MS)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the Medical Expert Institute.
20. **in the case of the loss of hearing**
    a) all medical documents produced in relation to the loss of hearing,
    b) the audiograms evidencing the occurrence of the insured event.

21. **In the case of the loss of vision**
    a) all medical documents produced from the commencement of visual deterioration to the notification of the insurance claim,
    b) the expert opinion of the Medical Expert Institute.
22. **in the case of the loss of speech**
    a) all medical documents produced from the loss of speech to the notification of the insurance claim,
    b) the expert opinion of the Medical Expert Institute.
23. **in the case of aplastic anaemia**
    all medical documents produced in relation to the illness, including documentation on transfusions.
24. **In the case of haemophilia**
    all medical documents produced in relation to the illness, including documentation on factor supplementation.
25. **In the case of Osler disease**
    all medical documents produced in relation to the illness, including documentation on transfusions.
26. **In the case of Hepatitis C virus infection**
    all medical documents produced in relation to the illness.
27. **In case of 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. **In the case of ulcerative colitis**
    a) all medical documents produced in relation to the illness,
    b) the surgery discharge summary with the operative report.
29. **In the case of familial adenomatous polyposis (FAP)**
    a) all medical documents produced in relation to the illness.
    b) the surgery discharge summary with the operative report.
30. **In the case of Crohn's disease**
    a) all medical documents produced in relation to the illness.
    b) the surgery discharge summary with the operative report.
31. **In the case of 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 confirmation.
32. **In the case of a nephrostomy surgery**
    a) all medical documents relating to the disease, including the results of the urological follow-up examination performed at least six months after the surgery;,
    b) the surgery discharge summary with the operative report.
33. **In the case of end-stage lung disease**
    a) all medical documents produced in relation to the illness.
    b) the expert opinion of the Medical Expert Institute.
34. **in the case of rheumatoid arthritis (RA)**
    a) all medical documents produced in relation to the illness.
    b) the expert opinion of the Medical Expert Institute.
35. **in the case of ankylosing spondylitis (Bekhterev's disease)**
    a) all medical documents produced in relation to the illness.
    b) the expert opinion of the Medical Expert Institute.
36. **In the case of amputation**
    hospital discharge summary/summaries and operative report/s in relation to the amputations.
37. **in the case of facial nerve paralysis**
    all medical documents relating to the illness, including the results of a follow-up examination at least 6 months after the surgery.
38. **In the case of esophageal stricture**
    all medical documents relating to the illness, including the results of a follow-up examination at least 6 months after the surgery.
39. **In the case of constrictive pericarditis**
    all medical documents produced in relation to the illness, including documentation on the cardiology examination preceding the surgery.
40. **In the case of chronic acquired inflammatory skin disease**
    all medical documents from the time the disease is diagnosed until the date of the insurance claim, including medical records of treatment referred by a dermatologist authorized to treat the disease.

III.4. **In addition, in the event of death resulting from any insured event specified in these special conditions, copies of the following documents must be submitted if they are necessary to establish the legal basis and/or amount of the reported claim:**
   a) the relative's copy of the death investigation certificate/death case summary,
   b) the insured's certificate of death,
   c) medical records stating the date on which the **illness causing** the insured's death, or **the underlying illness leading to surgery**, was first diagnosed and describing the course of that illness, as well as documents necessary to clarify the immediate circumstances of the death, such as a treating physician's certificate, hospital discharge summary, autopsy 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.6. **The insurance company is entitled to have the medical necessity of the medical treatment and medical care, and the insured person's state of health, examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

III.7. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

IV.1. In the case of this insurance policy, the insurance company will be exempted from the payment of the critical illness benefit in the cases described 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, contrary to Clause VII.1.1 c) of the general conditions, insurance cover extends to HIV infection, unless it can be evidenced that the insured person was already HIV-infected at the time of submitting the application.

Effective date of this supplement to the special conditions: June 26, 2026.

Special conditions of insurance cover for incapacity for work (KEKEK/02026)

These special conditions apply to the **incapacity for work insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. CONDITIONS FOR TAKING OUT INSURANCE COVER FOR INCAPACITY FOR WORK

I.1. Under these special conditions, insurance cover for incapacity for work may not be taken out for any person **who is not entitled to sickness benefit** under the compulsory health insurance system.

I.2. **The policyholder/insured person shall notify** the insurance company in writing **within 15 days** if their **entitlement to sickness benefit** under the compulsory health insurance system **ceases during the period of insurance**. In this case, the part of the policy that contains insurance cover for incapacity for work shall terminate in respect of the given insured person on the first day of the month following the cessation of entitlement to sickness benefit.

I.3. If, in respect of the given insured person, the part of the policy containing insurance cover for incapacity for work has terminated pursuant to Clause I.2, insurance cover for this risk may be reinstated, after the reason for termination has ceased to exist, with the insurance company's consent, on the basis of the written request of the policyholder and the insured person and the risk assessment carried out by the insurance company.

II. INSURED EVENT

II.1. An insured event means an accident or unexpected illness (Clauses IX.1 and IX.2 of the general conditions) that occurs during the period of insurance cover, had no antecedent at the commencement of insurance cover, **and as a result of which the insured is certified**, in accordance with the laws in force **by a physician** authorized to assess and certify incapacity for work, **as being continuously incapacitated for work in their own right and receives statutory sick pay in Hungary**.

II.2. The **date of the insured event** shall be the **date of the accident** in the case of the insured person's accident-related incapacity for work, and the **first day of sick leave** in the case of the insured person's illness-related incapacity for work.

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

III.1. The insurance company shall **pay the benefit, in the event of the insured person's illness, for days of incapacity for work during the period of insurance cover and, in the event of the insured person's accident, for days of incapacity for work occurring within two years from the date of the accident where such incapacity is necessary to address the consequences of the accident,** having regard to Clauses III.2 and III.3 of these conditions.

III.2. **The insurance will not cover the first specified number of days of continuous incapacity (hereinafter: elimination period) as stated in the insurance policy (insurance application).**

III.3. **The amount of the benefit** is determined **by multiplying the sum insured fixed in respect of this cover in the policy document or index letter in force at the time when the insured becomes incapacitated for work, by the number of days on which the insured was considered incapable of work, taking into account the elimination period.**

III.4. If **the insured's incapacity for work**, or any part of it, **due to an accident arises after this insurance policy has terminated but within two years of the insured's accident** that occurred during the period of insurance cover, the benefit shall be calculated on the basis of **the sum insured specified for this insurance risk in the last policy document or indexation letter in force.**

III.5. **Where** the insurance anniversary date falls within a period during which the insured person was certified as incapacitated for work, and **the insurance policy is subject to indexation** (Clause IV.7 of the general conditions), the insurance company shall, from the insurance anniversary date, **pay the increased benefit amount corresponding to the indexation to the insured person**.

III.6. **In the event of incapacity for work due to illness, the insurance company will pay benefits for a maximum of 90 days per policy year, and in the event of incapacity for work resulting from an accident, in connection with any one accident, the insurance company shall pay the benefit for a maximum of 150 days within two years from the date of the accident.**

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) the form issued by the physician authorized to determine incapacity for work, prescribed under applicable legislation for certifying incapacity for work (“Medical certificate of placement on incapacity-for-work [pregnancy-related] leave”),
b) if the insured was hospitalized: the hospital discharge summary, within 15 days after the end of the hospital treatment;
c) additionally, if the **insured event is the result of an accident**:
   – all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   – the accident report / workplace accident report, if one was prepared,
   – the result of any blood alcohol and/or narcotic substance test, if such test was performed,
d) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured **was injured in a traffic accident** as the **driver of a vehicle**, the insured's driving license and the vehicle registration certificate.

IV.4. **in the case of continuous incapacity for work:**

a) the documents specified in Clauses IV.3.1 and IV.3.2 c), d) need only be submitted upon the first notification,
b) a copy of the medical certificate of continuous incapacity for work issued by the physician authorized to assess incapacity for work in accordance with applicable legislation must be submitted to the insurance company within 14 days of its issue, quoting the policy number (“Medical certificate of continuous incapacity for work”),
c) new physician’s certifications on the insured’s medical conditions are required to be submitted by the insured to the insurance company at least once in every 60 days.

IV.5. **The insurance company is entitled to have the medical necessity of the medical treatment and medical care, and the insured person’s state of health, examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

IV.6. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company’s benefit shall not become due until the insured person enables the medical examination to be carried out.**

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

V.1. For this insurance, the insurance company shall be released from its obligation to pay the benefit for the insured's incapacity in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

V.2. In addition to the cases specified in the general conditions, insurance cover shall not extend to any period of incapacity for work during which the insured person carries out gainful activity.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for lump-sum incapacity-for-work benefit (KEKEK/12026)

These special conditions apply to **the lump-sum incapacity-for-work benefit insurance cover under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated by these special conditions shall be governed by the **General Terms and Conditions of Pajzs Group Insurance** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. CONDITIONS FOR TAKING OUT INSURANCE COVER FOR INCAPACITY FOR WORK

I.1. Under these special conditions, insurance cover for incapacity for work may not be taken out for any person **who is not entitled to sickness benefit** under the compulsory health insurance system.

I.2. **The policyholder/insured person shall notify** the insurance company in writing **within 15 days** if their **entitlement to sickness benefit** under the compulsory health insurance system **ceases during the period of insurance**. In this case, the part of the policy that contains insurance cover for incapacity for work shall terminate in respect of the given insured person on the first day of the month following the cessation of entitlement to sickness benefit.

I.3. If, in respect of the given insured person, the part of the policy containing insurance cover for incapacity for work has terminated pursuant to Clause I.2, insurance cover for this risk may be reinstated, after the reason for termination has ceased to exist, with the insurance company's consent, on the basis of the written request of the policyholder and the insured person and the risk assessment carried out by the insurance company.

I.4. Under these special conditions, insurance cover for incapacity for work with lump-sum benefit may not be taken out where the total headcount is fewer than 10 persons.

II. INSURED EVENT

II.1. An insured event means an accident or unexpected illness (Clauses IX.1 and IX.2 of the general conditions) that occurs during the period of insurance cover, had no antecedent at the commencement of insurance cover, **and as a result of which the insured is certified**, in accordance with the laws in force **by a physician** authorized to assess and certify incapacity for work, **as being continuously incapacitated for work in their own right and receives statutory sick pay in Hungary**.

II.2. The **date of the insured event** shall be the **date of the accident** in the case of the insured person's accident-related incapacity for work, and the **first day of sick leave** in the case of the insured person's illness-related incapacity for work.

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

III.1. If an insured event occurs, the insurance company **shall pay the sum insured specified for this insurance risk in the policy document or indexation letter in force at the time of the insured event or, after termination of the policy, in the last policy document or indexation letter in force,** based on the number of benefit days specified in the insurance application (14 or 28 days).

III.2. The insurance company shall not pay any benefit for the first number of days of incapacity for work specified in the policy (14 or 28 days).

III.3. The insurance company shall pay the benefit to the beneficiary only once in respect of any one insured event.

III.4. The insurance company shall pay the benefit to the beneficiary only once in any insurance year.

III.5. **If the insured person becomes incapacitated due to an accident after the termination of this insurance policy** but **within two years of the date of the accident** during the cover period, the amount of the benefit payable under this cover will be determined based on **the sum insured stated in respect of this cover in the last policy document or in the last indexation letter**.

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) a medical certificate confirming a recovery period exceeding 14 or 28 days,
b) all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
c) the accident/workplace accident report, if one was prepared,
d) the result of any blood alcohol and/or narcotic substance test, if such test was performed,
e) in the case of a traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured person **was injured** in a traffic accident **as the driver of a vehicle**, the vehicle registration certificate,

IV.4. **The insurance company is entitled to have the insured person's state of health examined by physicians designated by the insurance company and, depending on the result, to accept or reject the benefit claim.**

IV.5. **The insurance company may make payment of the benefit conditional on a medical examination; if it does so, the insurance company's benefit shall not become due until the insured person enables the medical examination to be carried out.**

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

V.1. **For this insurance, the insurance company shall be released from its obligation to pay the benefit for the insured's incapacity in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.**

V.2. **In addition to the cases specified in the general conditions, insurance cover shall not extend to any period of incapacity for work during which the insured person carries out gainful activity.**

Effective date of these special conditions: June 26, 2026.

Special conditions of term life insurance (KÉHAT/02026)

These special conditions apply to the **insurance cover for death under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

Matters not regulated in these special conditions shall be governed by the **general terms and conditions of Pajzs group insurance** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy was concluded.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event means **the death of the insured person during the period of insurance cover.**

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

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

If the insured dies during the period of insurance cover, **the insurance company shall pay the life insurance sum insured specified in respect of this cover in the policy document or indexation letter in force at the time of death or, after termination of the policy, in the last policy document or indexation letter in force,** to the beneficiary entitled to the death benefit.

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the notified claim:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**

a) the relative's copy of the death investigation certificate/death case summary,
b) the autopsy report, if one was prepared,
c) the insured's certificate of death,
d) if the insured **dies as a result of an illness**:
   – documents required to clarify the initial date and course of the illness causing the insured person's death and the detailed circumstances of the death, such as an attending physician's certificate, discharge summary, etc.,
e) if the insured **dies as a result of an accident**:
   – all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   – the accident / workplace accident / police report, if one was prepared,
   – the result of any blood alcohol and/or narcotic substance test, if such test was performed,
f) **in the case of a traffic accident**, in addition to the above: if the insured person **was injured or died in a traffic accident as the driver of a vehicle**, the insured person's driving licence and the vehicle registration certificate,
g) the **document evidencing entitlement as beneficiary**, such as a final probate order or certificate of inheritance, provided that the beneficiary was not named in the policy.

IV. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for death in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for the death of a spouse (KÉHAT/12026)

These special conditions apply to the **insurance cover for the death of a spouse under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

In matters not regulated in these special conditions, the **general terms and conditions of Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy has been concluded, **shall apply**.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. DEFINITION OF CO-INSURED PERSON

For the purposes of the insurance policy concluded on the basis of these special conditions, **the spouse of the person insured under the policy** or, in the absence of a spouse, **their cohabiting partner with whom they have lived for at least one year** shall **qualify as the insured person** (hereinafter: co-insured person).

II. INSURED EVENT

II.1. For the purposes of this policy, an insured event means **the death of the co-insured person during the period of insurance.**

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

III. BENEFIT PAYABLE BY THE INSURANCE COMPANY

If an insured event occurs, the insurance company shall pay, as the death benefit, **the sum insured specified in the policy document or indexation letter in force at the time of the insured event to the co-insured's heir or heirs**. Upon the occurrence of the insured event, the part of the policy relating to the given co-insured person shall terminate.

IV. CONDITIONS FOR THE PAYMENT OF CLAIMS

IV.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

IV.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

IV.3. **In addition to the documents specified in Clause V.3.2 of the general conditions applicable to the policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or amount of the reported claim:**

IV.3.1. the fully completed **insurance claim form** made available by the insurance company,

IV.3.2. **as well as copies of the following documents:**

a) the relative's copy of the death investigation certificate/death case summary,
b) the autopsy report,
c) the certificate of death,
d) if the insured **dies as a result of an illness**:
   – documents required to clarify the initial date and course of the illness causing the insured person's death and the detailed circumstances of the death, such as an attending physician's certificate, discharge summary, etc.,
e) if the insured **dies as a result of an accident**:
   – all medical documents issued in connection with the insured event between the accident and notification of the benefit claim, in particular the record of the first medical treatment,
   – the accident / workplace accident / police report, if one was prepared,
   – the result of any blood alcohol and/or narcotic substance test, if such test was performed,
f) in the case of a traffic accident, in addition to the above:
   if the insured person **was injured or died in a traffic accident as the driver of a vehicle**, the insured person's driving licence and the vehicle registration certificate,
g) a copy of the **document evidencing entitlement as beneficiary**, such as a final probate order or certificate of inheritance, provided that the beneficiary was not named in the policy.
h) in the case of a spousal relationship, the marriage certificate,
i) in the case of a cohabiting partner relationship, a declaration signed by two witnesses evidencing at least one year of cohabitation.

V. RELEASE OF THE INSURANCE COMPANY FROM BENEFIT PAYMENT AND EXCLUSIONS

For this insurance, the insurance company shall be released from its obligation to pay the benefit for death in the cases specified in Chapter VI of the general conditions, and insurance cover shall not extend to the cases listed in Chapter VII of the general conditions.

Effective date of these special conditions: June 26, 2026.

Special conditions of insurance cover for childbirth benefit (KÉGYR/02026)

These special conditions apply to the **insurance cover for childbirth benefit under the Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy was concluded by reference to these special conditions.

In matters not regulated in these special conditions, the **general terms and conditions of Pajzs group insurance policies** of Generali Biztosító Zrt. (hereinafter: general conditions), by reference to which the insurance policy has been concluded, **shall apply**.

In all other respects, the provisions of the **Hungarian Civil Code** and **other applicable Hungarian legislation** shall apply to the policy as appropriate.

I. INSURED EVENT

I.1. An insured event occurs if **a live child is born to the insured person during the term of the insurance policy.**

I.2. The date of the insured event shall be **the date of birth of the child.**

II. BENEFIT PAYABLE BY THE INSURANCE COMPANY

II.1. When an insured event occurs, **the insurance company shall pay the sum insured specified in respect of this cover in the policy document or indexation letter in force on the date of the insured event.**

II.2. **In the case of twin birth or multiple birth, the insurance company shall pay a multiple of the sum insured corresponding to the number of children born.**

III. CONDITIONS FOR THE PAYMENT OF CLAIMS

III.1. The benefit claim must be notified to the insurance company **within 15 days after the insured event**.

III.2. Where **the above time limit is not met** and material circumstances therefore become impossible to ascertain, **the insurance company may be released from its obligation to pay the benefit.**

III.3. **At the time of notifying an insurance claim, the following documents shall be submitted in addition to the ones set forth in Clause V.3.2 of the general conditions governing the insurance policy:**

III.3.1. the fully completed **insurance claim form** made available by the insurance company,

III.3.2. **as well as copies of the following documents:**
a) the birth certificate(s) of the child(ren),
b) the hospital discharge summary,

IV. EVENTS EXCLUDED FROM THE INSURANCE COVER

IV.1. Insurance cover shall not extend to the cases specified in Clause VII.2 of the general conditions applicable to the policy.

IV.2. An insured event connected with a pregnancy existing before submission of the application shall not give rise to the insurance company's obligation to pay a benefit.

Effective date of these special conditions: June 26, 2026.