General and Special Conditions of Pajzs Group Insurance for Persons Travelling in Vehicles (KJÁSF/02026)

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General conditions of Pajzs group insurance for persons travelling in vehicles (KJÁSF/02026)

These general conditions of Pajzs group insurance for persons travelling in vehicles (hereinafter: general conditions) apply to the policies of Generali Biztosító Zrt. (hereinafter: insurance company) that include accident insurance cover (hereinafter: policy), provided that the policy has been concluded by reference to these general conditions.

The general conditions are supplemented by the **special conditions** of accident insurance containing the covers selected by the policyholder in the insurance application.

In matters not regulated in these general conditions or the special conditions, the document forming part of the insurance policy titled "Customer Information of Generali Biztosító Zrt. and General Provisions Governing the Insurance Policy" (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 policy and subject matter of the insurance

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** means a natural person acting outside the scope of their profession, self-employed occupation or business activity.

II.1.3. The **insured persons** are the natural persons travelling in the vehicle named in the policy, including the driver, in respect of whose life and health-related events the policy is concluded.

II.1.4. Under the policy concluded on the basis of these general conditions, the insured persons shall be entitled to identical insurance benefits.

II.1.5. **The insured may not replace the policyholder in the insurance policy.**

II.1.6. **Beneficiary** shall be any person who is entitled to receive the insurance benefit. The beneficiary of all insurance benefits due in the life of the insured shall be the insured himself, and should the insured die, the heir(s) of the insured.

II.2. Conclusion and amendment of the policy

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

II.2.2. The policy **may be taken out for the following vehicles**: passenger car, bus, tractor unit, semi-trailer tractor, goods vehicle, slow vehicle, vessel, and narrow-gauge railway.

II.2.3. 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.2.4. The Policyholder shall be bound by its insurance application for 15 days from the date it is made.

II.2.5. The policyholder's declarations and their answers to the questions asked by the insurance company form part of the insurance application documentation.

II.2.6. 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.2.7. **The insured's consent is not required for the conclusion, amendment or termination of the insurance policy.**

II.2.8. **The policy is concluded when the insurance company accepts the policyholder's insurance application by sending the policy document to the policyholder.**

II.3. Commencement and termination of insurance cover and the definition of policy anniversary

II.3.1. In respect of persons travelling in the vehicles specified when the insurance application is submitted, insurance cover shall commence, unless otherwise agreed by the parties, at the time specified in the insurance application, provided that the policyholder has paid the insurance premium to the insurance company.

II.3.2. Where the policyholder requests that the scope of the policy be extended to a new vehicle (Clause III.1.3) after the policy has been concluded, the insurance cover in respect of persons travelling in that vehicle shall commence at 00:00 on the day following receipt by the insurance company of the notification of change, provided that the policyholder has paid to the insurance company the insurance premium calculated on the basis of the new vehicle included in the policy.

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) where the policyholder requests in writing that the insured vehicle be removed from the scope of the policy (Clause III.1.3), the insurance cover in respect of persons travelling in that vehicle shall terminate at 00:00 on the first day of the month following receipt by the insurance company of the notification of change,

c) 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.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 as 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. Term and geographical limit of the insurance

Insurance cover extends to persons travelling in the vehicles included in the insurance cover, including the driver, while boarding or alighting from the vehicle and during travel.

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

III.1. Rights and obligations of the parties to the insurance policy

III.1.1. The **policyholder shall inform** the insured persons of the content of the insurance policy and any changes thereto.

III.1.2. The policyholder shall, for the conclusion of the policy, state in the insurance application the registration number of the passenger car, bus, tractor unit, semi-trailer tractor, goods vehicle or slow vehicle included in the policy, the identification number or registration number of the insured vessel, or the route of the insured narrow-gauge railway, specifying the terminal stations.

III.1.3. The policyholder may, without the consent of the insured persons, request **amendment** of the policy to include a new vehicle or vehicles in the policy (hereinafter: **new vehicle**), or to terminate insurance cover in respect of a vehicle or vehicles included in the policy (hereinafter: **removed vehicle**). 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. For the conclusion and amendment of the policy, the vehicle or vehicles included in the policy must have a valid registration certificate and/or official authorisation, as well as valid compulsory third-party liability insurance. The insurance company may request presentation of the valid original documents at any time during the term of the policy.

III.1.5. **During the term of the policy, the scope of benefits (risks) and the sums insured may not be amended.**

III.1.6. Under the insurance policy, the insurance company is obliged to provide the benefits specified in the policy conditions.

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

III.2.1. The policyholder shall comply with its duty of disclosure and duty to notify changes.

III.2.2. The duty of disclosure and notification of changes shall be borne by the policyholder. The policyholder may not rely on any circumstance which it failed to disclose to the insurance company, although it should have known of that circumstance and was obliged to disclose or notify it.

III.2.3. **Under the duty of disclosure**, at the time of concluding the policy and when notifying a benefit claim relating to the insurance policy, the policyholder shall disclose to the insurance company all circumstances that are material for the acceptance of the insurance risk and for the assessment of the benefit claim, and of which the policyholder was or should have been aware. The parties shall 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. During the term of the insurance, the policyholder 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.

A **material circumstance** means any matter about which the insurance company asked a question. The duty to notify changes applies in particular to changes in the policyholder's name, address or mailing address, and to changes in the fleet of vehicles included in the policy.

III.2.5. The insurance company shall be entitled to verify the disclosed data.

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. Where the insurance company becomes aware of material circumstances affecting the insurance policy after the policy has been concluded, or is notified of changes in material circumstances, and those circumstances result in a significant increase in the insurance risk, the insurance company may, within 15 days of becoming aware of them, make a written proposal to amend the insurance policy or terminate the policy in writing in respect of the vehicle concerned, with 30 days' notice.

A **considerable increase in the insured risk** shall include cases when had the insurance company known about the material circumstance, it would have applied a premium adjustment, surplus premium or exclusion, or it would have denied cover. If the insurance company fails to exercise this right, the insurance policy shall remain in force on the original terms.

III.3.2. If the policyholder declares in writing, within 15 days of receipt of the proposed amendment, that it **does not accept** the proposed amendment, the policy or this part of the **policy 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.

IV. INSURANCE PREMIUM

IV.1. Insurance Premium

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

IV.2. Determination of the insurance premium

The insurance premium is calculated on the basis of the insurance company's Premium Rating Schedule, taking into account in particular the total number of seats shown in the registration certificate and/or official permit of the vehicles included in the policy, and the sum insured or sums insured.

IV.3. Insurance premium per seat for the insured persons

IV.3.1. The annual insurance premium per seat shall be the quotient of the annual premium of the policy and the total number of seats in the vehicles included in the policy. Within a single policy, the insurance premium per seat shall be identical.

IV.3.2. In the case of a new vehicle or a removed vehicle (Clause III.1.3), the insurance company shall amend the insurance premium of the policy in accordance with the premium specified in Clause IV.3.1, with effect from the first day of the month following notification of the change.

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 the entire policy in a single amount, in accordance with the due date of the premium or premium instalment.

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

The insurance policy may not be reinstated.

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 deadline for notifying 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 the payment of claims

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:

a) the registration certificate or official authorisation of the vehicle included in the policy in which the insured person who suffered the accident was travelling,
b) the list of persons travelling in the vehicle, if one was prepared,
c) the 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 the witnesses,
d) the ticket or pass authorizing travel, if the service is scheduled,
e) if necessary, the verification of the fact that the particular insured is covered under the insurance policy.
f) a duly completed standard insurance claim form made available by the insurance company,
g) the documents specified in the applicable special conditions.

V.3.2.1. **Documents suitable for the clarification of all the circumstances and consequences of the insured event** (a statement by the insured and/or any other person involved in the insured event about the circumstances of the insured event, the accident report or decision issued by the police, the employer, the school, or the passenger carrier company, expert opinions in connection with the accident/consequences);

V.3.2.2. **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.3.2.3. 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.3.2.4. **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.3.2.5. 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.3.2.6. An official certificate in proof of the insured's date of birth;

V.3.2.7. 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.3.2.8. 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.3.2.9. 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.3.2.10. 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.3.2.11. 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. A benefit claim notified to the insurance company **shall become payable on the 15th day following receipt of all documents required for its assessment.** 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 its obligation to pay accident insurance benefits

VI.1.1. **If the policyholder 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 breached its duty to notify changes, but the concealed or unreported circumstance became known to the insurance company during the period of insurance, before the insured event occurred, and the insurance company did not exercise its right to amend or terminate the policy under Clause III.3 of these general conditions within 15 days, or**

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

VI.1.2. **The insurance company shall be released from its obligation to pay the benefit if the insurance company proves that the loss was caused unlawfully and intentionally or unlawfully and by grossly negligent conduct by:**

a) **the policyholder or the insured person;**

b) **the relative living in the same household as them, their member authorised to manage the business, or their employee, member or agent holding a position specified in the general terms and conditions, or**

c) **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.**

VI.1.3. **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. If the insured fails to comply with this obligation, the insurance company shall be released from its benefit payment obligation.**

VI.1.4. **The insurance company shall be released from its obligation to pay the benefit if the insured person dies as a result of the beneficiary's intentional conduct.**

VII. EVENTS EXCLUDED FROM THE INSURANCE COVER

VII.1. Exclusions applicable to accident 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), insurance cover extends to impairments in the insured person's health arising in connection with the insured person's active participation in demonstrations, strikes or marches that have been notified in advance and held in accordance with the provisions of Hungarian law in force, provided that the insured person has complied with their obligation to prevent and mitigate the loss.**

VII.1.4. **Insurance cover shall not extend, for a period of 5 years from the commencement of insurance cover for the relevant risk in respect of the insured person concerned, to events that are causally related, in whole or in part, to the cases listed below:**

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 insured was verifiably under the influence of alcohol, a narcotic drug or a psychoactive substance at the time of the insured event, and this fact contributed to the occurrence of the insured event. If a blood alcohol test was administered, the insured person shall be deemed to be under the influence of alcohol if their blood alcohol concentration exceeds 1.5‰, or exceeds 0.8‰ while driving a motor vehicle,

b) the insured drove a motor vehicle that did not have a valid registration certificate, or did not hold the valid driving license required to drive that vehicle, and this fact contributed to the occurrence of the insured event;

c) the insured travelled in a motor vehicle that did not have a valid registration certificate, and this fact contributed to the occurrence of the insured event;

d) the occurrence of the insured event is causally related to the fact that, at the time of the insured event, the insured person breached at least two traffic regulations,

e) the insured event occurred in connection with the insured person's failure to comply with, or disregard of, the instructions or warnings communicated by the policyholder concerning the use of the vehicle,

f) the insured event occurred in connection with the fact that a vehicle was made available to the insured persons which, at the time of the insured event, did not have a valid registration certificate and/or official authorization, or valid compulsory motor third-party liability insurance.

VII.1.6. 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) 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,

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

VII.1.7. The insurance does not cover mental-function disorders or psychiatric illnesses.

VII.1.8. Insurance cover shall not extend to events caused by racing with a vehicle included in the policy on a public road or on any other terrain suitable for racing.

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 gets lost or is destroyed, the insurance company shall, at the request of the policyholder, issue a new policy document with the same content as that of the policy in force.

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. Definition of 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, tetanus infection shall also qualify as an accident if it is diagnosed in connection with the accident and medical attention is first sought for the symptoms within 20 days following the date of the accident. 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) the insured person's suicide or attempted suicide, even if it occurs while the insured person is in a disturbed state of mind;
c) 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;
d) 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.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 care 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 surgical groups (hereinafter: classification into surgical groups). The classification of surgical groups by surgical benefit category (hereinafter: the Surgical List) is set out in Annex "B" to these Conditions. The insurance company has assessed all WHO-coded surgical procedures for the purposes of surgical benefit payment, with the proviso that surgical procedures that do not fall within any of the groups listed in the Surgical List belong to surgical benefit category 5, "not covered" (e.g. diagnostic tests and procedures, including histological sampling and cytology, injection and infusion treatments, physiotherapy and chemotherapy).

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 group insurance for persons travelling in vehicles that materially deviate from the provisions of the Civil Code and from standard contractual practice.

X.1. Provisions of the General Conditions which substantially derogate from the provisions of the Hungarian Civil Code

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

Pursuant to Clause II.2.6 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.2.7 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 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. Additional payment deadline

Pursuant to Clause IV.5.1 of these conditions, and by way of derogation from Section 6:449(1) of the Civil Code, 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.

X.1.3. Limitation period

The provision on the statute of limitations set out in Clause VIII.1 of these conditions differs from the five (5) year limitation period prescribed in Section 6:22. (1) of the Civil Code. 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

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 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 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 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. 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 incurs the accident expenses specified 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 issued in connection with the insured event between the accident and notification of the benefit 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) **jewelry 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 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 the 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** occurring during the period of insurance cover (Clause IX.1 of the general conditions) **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 company shall pay a benefit for surgeries 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 surgery is 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 occurring during the period of insurance cover (Clause IX.1 of the general conditions) **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 applicable percentage 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, depending on the severity of the burn injury.**

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.