General Terms and Conditions of Passenger Accident Group Insurance (KJÁSF/02017)

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Contents

General Terms and Conditions of Passenger Accident Group Insurance (KJÁSF/02017)

These General Terms and Conditions of Passenger Accident Group Insurance (hereinafter: General Conditions) set out the standard terms and conditions for insurance policies (hereinafter: policy) offered by Generali Biztosító Zrt. (hereinafter: the insurance company) with accident insurance cover, provided that the policy has been concluded by reference to these General Conditions.

These General Conditions shall be supplemented by the **Special Conditions** of the accident insurance products with benefits of the policyholder's choice specified on the insurance application form.

All matters not regulated by these General Conditions or the Special Conditions, will be governed by the provisions of the **Hungarian Civil Code** or the provisions of other **effective Hungarian legislation.**

The provisions of the Special Conditions may derogate from the provisions set out herein, in which case the provisions of the Special Conditions shall prevail.

In the event of discrepancy between the document titled 'Customer Information and General Provisions governing Insurance Policies' and the policy conditions, the provisions of the policy conditions shall prevail.

I. CONTENT OF THE INSURANCE POLICY

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

II. GENERAL PROVISIONS

II.1. Parties to the Insurance Policy, the Subject of the Insurance

II.1.1. Insurance Company is a legal entity which, in consideration of the payment of insurance premium, provides coverage for the insured risk(s) and undertakes the obligation to pay insurance claims pursuant to the Special Conditions.

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

II.1.3. The **insured persons** shall be the natural persons (including the driver) who travel in the vehicle specified in the policy, and whose life or health is covered in the insurance policy with respect to specific insured events.

II.1.4. Under any policy concluded pursuant to these General Conditions, the insured persons shall be eligible for identical insurance benefits.

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

The consent of the guardian authority is not required even if the insured is a person whose legal capacity has been partially limited in respect of making legal statements relating to property, or if the insured person is an incompetent adult.

II.1.6. **The insured may not replace the policyholder in the insurance policy.**

II.1.7. **Beneficiary** is the 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 if the insured dies, the beneficiary shall be the heir(s) of the insured.

II.2. Conclusion and modifications of the insurance policy

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

II.2.2. This insurance **may be taken out** to insure the following vehicles: automobile, bus, tractor, traction unit, truck, slow-moving vehicle, boat, dinkey.

II.2.3. Any insurance premium or premium installment paid by the policyholder prior to the conclusion of the insurance policy shall be deemed as an advance premium, which the insurance company will handle free of interest. If the insurance policy is concluded, the advance premium is fully offset against the insurance premium.

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

II.2.4. The insurance company is entitled to carry out **underwriting** before it approves an insurance application or extends an insurance coverage. **The insurance company shall be entitled to verify the data so obtained.**

II.2.5. The policyholder is bound by the insurance application for 15 (fifteen) days of its date of submission.

II.2.6. Declarations made by the policyholder and the policyholder's answers to the questions raised by the insurance company shall be integral parts of the insurance application.

II.2.7. The findings of the underwriting procedure will determine whether the insurance company approves or denies the insurance application or the coverage modification, or proposes an amendment. The insurance company is not required to give reasons for the denial of the insurance application or the expansion/modification of the insurance coverage, or for any proposed amendments.

II.2.8. If the **certificate of coverage is issued with terms which differ from** the terms of the **insurance application** or in the case of a policy modification, they differ from the terms of the **modification proposal,** and **this difference is not contested** by the policyholder without delay, or **within a maximum of 15 days, the policy will take effect/will be modified on the different terms.**

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

II.2.9. **The insurance policy may be modified without the consent of the insured.**

II.2.10. **The insurance policy is validly concluded if the insurance company approves the insurance application completed by the policyholder and delivers the respective policy documentation.**

II.2.11. The policy shall be executed – by the insurance company's implicit conduct – on the terms of the application, also if the insurance company fails to respond to the insurance application within fifteen (15) days of its receipt, provided that the application was made on the insurance company's own standard application form for the type of policy in question, upon receipt of the relevant statutory information, containing the premium rates applicable.

In that case, the insurance policy shall be concluded with retroactive effect to the date when the insurance company was delivered the insurance application.

II.2.12. If a policy which is concluded without the express statement of the insurance company derogates in material terms from the standard insurance terms and conditions, the insurance company will have 15 days of the conclusion of the insurance policy to propose that it be modified according to the standard terms.

If the policyholder refuses the proposed modification or fails to respond to it within 15 days, the insurance company may terminate the policy giving 30 days written notice within 15 days upon receipt of the notification of the refusal or modification. (Subsequent termination of a contract concluded by implicit conduct.)

II.3. Commencement and termination of the insurance coverage and the waiting period

II.3.1. Unless otherwise agreed by the parties, the insurance coverage applicable to the persons traveling in the vehicles specified on the insurance application shall commence at the date specified on the insurance application, provided that the policyholder has paid the insurance premium to the insurance company.

II.3.2. If the policyholder requests that a new vehicle (III.1.3) be added to the insurance coverage after the conclusion of the policy, the insurance coverage with respect to the passengers will commence at 0 a.m. on the day following the date when the change request is received by the insurance company, provided that the policyholder has paid the insurance premium determined for the coverage of the new vehicle to the insurance company.

II.3.3. **With respect to the particular insured persons, the insurance coverage will terminate in the following cases:**
a) if the insured dies, at the time of the death,
b) if the policy is cancelled by the parties in accordance with Clause II.5.2 and if it is terminated by the insurance company in accordance with Clause III.3,
c) if the policyholder initiates that an insured vehicle be withdrawn from the insurance policy (III.1.3.), the insurance coverage of the persons travelling in the given vehicle shall terminate at 0 a.m. on the first day of the month after the change notification was received by the insurance company,
d) in other cases and in the manner set forth in the Special Conditions.

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

If the commencement of the coverage is the first day of any month, that date shall also be the date of the insurance anniversary.

The parties may agree to derogate from the provisions stipulated herein, subject to their mutual consent.

II.4. Policy Period

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

II.5. Termination of the insurance policy

II.5.1. **The policy shall terminate:**
a) if the insurance premium is not paid by the due date set out in Clause IV.5.2;
b) if the policyholder entity is terminated without legal succession, at the date of its termination,
c) in the event of the subsequent termination of a policy concluded by implicit conduct (tacit policy) (Clause II.2.12), or if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, at the end of a 30-day notice period (Clause III.3),
d) if cancelled by the policyholder or **the insurance company.**

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

II.6. Coverage Period, Geographical Limit

The insurance coverage shall apply to the persons traveling in the insured vehicle (including its driver), throughout the duration of the journey including getting on and off the vehicle.

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

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

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

III.1.2. For the conclusion of the policy, the policyholder is required to state on the application form the license plate numbers of every insured automobile, bus, tractor, traction unit, truck or slow-moving vehicle, the ID or registration number of every insured boat or ship, and the route of the insured dinkey (by specifying end stops).

III.1.3. The policyholder may initiate that the **insurance policy be amended** or modified, a new vehicle (vehicles) be added to the coverage (hereinafter: **new vehicle**), or the insurance coverage of a vehicle (vehicles) specified in the policy be terminated (hereinafter: **vehicle withdrawn**). The insurance company may approve or deny the proposed modification or may propose an amendment thereof. The insurance company is not required to give reasons for the denial or for the proposed amendments.

III.1.4. The policy may only be concluded or amended subject to the presentation of a valid vehicle registration certificate and/or official license of the insured vehicle (or vehicles), and the vehicle(s) shall have effective compulsory motor TPL insurance. During the coverage period, the insurance company may, at any time, request that the valid, original documents are presented.

III.1.5. **During the policy period, the selected benefits (risks covered) and the related sums insured may not be modified.**

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

III.2.1. The policyholder is required to comply with the duty to disclose information and notify changes.

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

III.2.3. The **duty to notify changes** means that during the coverage period the policyholder is required to give **written notification** of any change in any relevant condition which have been disclosed on the insurance application or specified in the policy **within 5 workdays** following such change.

Relevant condition shall be everything that the insurance company has required to be stated. The duty to notify changes shall, in particular, apply to changes in the policyholder's name, address, mailing address, and the vehicle fleet insured under the contract.

III.2.4. The insurance company is entitled to verify any disclosed data.

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

III.3.1. If the insurance company becomes aware of any material circumstance regarding a policy, or any change thereof, only after the policy has been concluded, and these circumstances bring about a considerable increase in the insured risk, the insurance company shall be entitled to make a written proposal within fifteen days after gaining knowledge thereof to amend the policy or may cancel the coverage – with respect to the particular vehicle – in writing with thirty days' notice.

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

III.3.2. If the policyholder notifies the insurance company within 15 days of receipt of the proposed amendment that he **does not accept** the proposed amendment, the policy or its respective provisions **will terminate** on the 30th day after the notification of the amendment was served.

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

IV. INSURANCE PREMIUM

IV.1. Insurance Premium

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

IV.2. Determining the Insurance Premium

The insurance premium shall be determined pursuant to the premium rates regulations of the insurance company with particular regard to the total number of seats entered into the vehicle registration certificate and/or official license of the insured vehicles, and to the sum/sums insured.

IV.3. Insurance Premium of Insured Persons Per Seat

IV.3.1. The insurance premium per seat shall be the quotient of the annual premium of the policy and the total number of seats within the insured vehicles. Under the same policy, the insurance premiums per seat shall be identical.

IV.3.2. In the case of a new or a withdrawn vehicle (Clause III.1.3.), the insurance company shall modify the insurance premium in accordance with the premium set out in Clause IV.3.1. with effect from the first day of the month following the date of the communication on the change.

IV.4. Payment of the Insurance Premium

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

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

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

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

IV.4.5. The policyholder agrees to pay all insurance premiums applicable to the whole policy in one sum, in accordance with the due dates of the premium (premium installment) payment.

IV.5. Consequences of Premium Payment Default

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

IV.5.2. If the policyholder fails to comply with his payment obligation **within the additional period,** the policy shall be terminated with effect to the date until premiums were paid, except if the insurance company forthwith moves to enforce its claim by judicial process.

IV.5.3. If only a part of the due premium is paid, and the insurance company's request – made in accordance with the provisions on premium payment default – to the policyholder for payment of the sum owed proved unsuccessful, the policy shall remain in force with the same amount of coverage for a term to which the premium paid corresponds.

IV.6. Reactivation

The insurance policy may not be reactivated.

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

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

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

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

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

IV.7.4. The insurance company shall issue a new certificate of coverage with the modified sum insured and insurance premium within 30 days of such change, save for the case when the insurance company has given notification of all changes of the insurance policy in the written notice set out in Clause IV.7.3.

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

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

IV.8. Adjustment of the Insurance Premium

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

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

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

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

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

V.1. Insured Events

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

V.2. Insurance Benefits, Covered Services

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

V.3. Payment of Claims – Payment Conditions

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

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

Where the **above time limit is not respected,** and the information required by the insurance company for the assessment of the insurance claim is not disclosed, or the insurance company is not allowed to verify the content of the disclosure, and as a result **material conditions or circumstances cannot be revealed, the insurance company may be released from its obligation to pay the claim.**

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

When the **notice of a claim under the accident insurance coverage of the policy is submitted,** the following documents shall also be attached in addition to those set out in the Special Conditions:

a) the vehicle registration certificate or official license of the insured vehicle which transported the insured who suffered the accident;
b) a list of the passengers travelling in the vehicle, if available,
c) the written accident & injury report drawn up by the policyholder, which shall contain the place and the exact time of the accident, the personal particulars of the person who is injured in the accident, the detailed circumstances and the consequences of the accident, as well as the personal particulars and contact details of the witnesses,
d) a ticket or travelcard valid for the journey, if the line is scheduled,
e) if necessary, the verification of the fact that the particular insured is covered under the insurance policy.

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

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

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

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

V.3.3.3. A **standard form** supplied by the insurance company and **completed by the insured's treating physician or the medical facility where the insured was treated, with medical information in connection with the insured event, the insured's medical conditions, and the insured's medical history;**

V.3.3.4. The insured's **medical documentation** produced in connection with the insured event and the insured's medical history: a copy of the medical file issued by a general practitioner, a company physician, or a physician supervising the insurance portfolio, documents produced during outpatient or inpatient care, and documents in proof of administration of pharmaceuticals;

V.3.3.5. **The documents managed by the social insurance body** or another person or organization, **containing data regarding the insured with respect to the insured event or a circumstance leading to such an event** (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);

V.3.3.6. The insured's sports club membership card or of the **membership certificate relating to any sports activities** which may impact the insurance coverage, the official match report;

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

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

V.3.3.9. The insurance company may also require that all documents necessary for the assessment of the insurance claim but **produced in a foreign language** shall be translated into Hungarian at the cost of the claimant, and the **official translations shall be submitted** to the insurance company for the decision making;

V.3.3.10. The insurance company may require that **original copies of such documents are presented** and that they are also submitted on any form of electronic media;

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

V.3.4. Deadline for Payment of Claim

V.3.4.1. The insurance company shall settle any filed insurance claim **within 15 (fifteen) days upon receipt of all documents necessary for the settlement of such claim.**

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

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

V.3.4.4. The costs of the medical examination shall be borne by the insurance company. Any costs incurred by the insured in relation to attending the medical examination shall be borne by the insured.

VI. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT

VI.1. The insurance company is released from its obligation to pay a claim for accident benefits

VI.1.1. If the policyholder or the insured infringe their obligation to disclose the required information or to notify changes, the insurance company's obligation to pay the claims shall not set in, unless the policyholder proves that any of the following circumstances exist:

a) the concealed or unreported circumstance was known to the insurance company at the time when the insurance policy was concluded, or

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

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

VI.1.2. The insurance company will be released from its obligation to pay the claim if the insurance company can prove that the loss or damage was caused unlawfully and willfully or unlawfully and in gross negligence.

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

a) the insured was demonstrably under the influence of alcohol, drugs or other stupefying agents at the time of the insured event, and this fact contributed to the occurrence of the insured event. If a blood alcohol test was administered, the person is legally intoxicated if his/her blood alcohol concentration exceeds 1.5‰ – or 0.8‰ while driving a motor vehicle,

b) the insured operated a motor vehicle without a valid vehicle registration certificate or the insured did not have a valid license required for driving such vehicle, and this fact intervened in the occurrence of the insured event,

c) he/she was travelling in a motor vehicle which did not have a valid vehicle registration certificate, and this fact contributed to the occurrence of the insured event,

d) the insured has committed at least two traffic offenses at the time of the insured event, and as such the insured event resulted directly from these actions;

e) the insured event was the result of the insured's non-compliance with or ignorance of the instructions or warnings communicated by the policyholder with respect to the use of the vehicle.

The policyholder shall be acting in gross negligence in particular if an insured event occurs in consequence of the fact that the vehicle made available by the policyholder to the insured persons does not have a valid vehicle registration certificate and/or official license and/or the vehicle(s) does not have compulsory motor TPL insurance.

VI.1.3. When an event underlying an insured event occurs, the insured is required to act as generally and reasonably expected in the given situation, and as such promptly seek emergency assistance or medical care. The insured's refusal of medical treatment – due to statutory patient autonomy and freedom to decide – shall not be a breach of their duty to mitigate loss. If the insured fails to comply with this obligation, the insurance company will be released from its obligation to pay the claim.

VI.1.4. The insurance company will be released from its obligation to pay the claim if the insured dies as a result of the beneficiary's willful misconduct.

VII. EVENTS EXCLUDED FROM INSURANCE COVERAGE

VII.1. Exclusions Applicable to Accident Insurance Covers

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

a) ionizing radiation,

b) nuclear energy,

c) HIV infection

d) war, combat operations, hostile actions of foreign forces, civil disorders, coup d'état or attempted coup d'état, riots, civil war, revolution, rebellion, demonstrations, processions, labor acts, terrorism, work misbehavior, border conflicts, insurrection.

VII.1.2. For the purposes of these General Conditions, terrorism shall in particular mean unlawful acts involving he use of violence or threat of violence especially against human life, tangible or intangible assets or the infrastructure, in the pursuit of political aims, religious, ideological, or ethnic change or intended to influence any government or to create fear and terror in the whole or a part of society, or which are suitable for the above.

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

VII.1.4. The insurance coverage shall not apply to events which are direct results of the following cases:

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

b) the insured's permanent disability established prior to the commencement of the insured's insurance coverage.

VII.1.5. The insurance does not cover events caused in whole or in part by:

a) hospital care which is NOT aimed at diagnosing the insured's illness, or preventing the further deterioration of the insured's condition, or restoring the insured's health, including but not limited to screening tests, or a parent staying at the hospital with his/her child, or the insured's stay at the hospital for the purpose of nursing a parent,

b) rehabilitation or nursing of chronic illnesses (especially geriatrics, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy, infusion therapy to improve blood flow, pain management infusion therapy), excluding treatments which are aimed at diagnosing a chronic illness, initiating a therapy, or preventing a significant deterioration of acute conditions,

c) treatment performed by a person who does not have medical certification and a license to practice medicine.

VII.1.6. The insurance does not cover psychological conditions, mental and psychiatric disorders.

VII.1.7. The insurance coverage shall not apply to events which are caused by racing with any of the vehicles insured under the policy, whether on public roads or on other areas suitable for racing.

VIII. MISCELLANEOUS PROVISIONS

VIII.1. Period of Limitation

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

The limitation period will commence at the following points in time:

a) if an insured event is not notified to the insurance company, then at the time when the insured event occurred,

b) if an insured event is notified to the insurance company, then on the day following the 15th day of the date when the last document was received by the insurance company,

c) if an insured event is notified to the insurance company and if the documents or information required by the insurance company are not submitted or disclosed, on the day following the deadline of the document submission or information provision set out by the insurance company, or in the absence of such a deadline, on the day following the 30th day of the issue date of the written communication served for that purpose.

d) in other cases, at the date when the claim falls due.

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

If the certificate of coverage gets lost or is destroyed, the insurance company shall, at the request of the policyholder, issue a new certificate of coverage with the same content as that of the effective one. Any costs incurred in this relation, shall be borne by the policyholder.

VIII.3. Procedure to Settle Disputes or Disagreement

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

IX. TERMS AND DEFINITIONS

IX.1. Accident and road traffic accident

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

IX.1.2. For the purposes of these General Conditions **accident also means** a tetanus infection if its symptoms develop in relation to the accident and it is first diagnosed by a physician within 20 days after the occurrence of the accident. The onset of the illness is the day when the insured has first turned to a physician in relation to the diagnosed tetanus infection.

IX.1.3. For the purposes of these General Conditions, notwithstanding the provisions set out in Clause IX.1.2., **accident does not mean:**

a) infection by infectious agents (bacteria, virus, protozoa) from human or animal primary-host (carrier) to a human body secondary-host (receiver) which infection occurred directly or indirectly (hereinafter together: transmission), not even in the event that the transmission occurred as result of an accidental physical cause, unless the Special Conditions stipulate this otherwise,

b) the insured's suicide or suicide attempt, even if it happened while the insured was in an altered mental status,

c) development of disc herniation, unless the disc herniation is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy disc,

d) damage to the articular joints, tendons, other soft-tissues, unless the damage is the result of a one-time, extreme, exterior, mechanical impact to an otherwise healthy joint.

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

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

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

IX.2.3. For the purposes of this insurance, **hospital does not mean** sanatoriums, rehabilitation centers, thermal or hydromineral establishments, psychiatric hospitals or psychiatric wards, geriatric nursing institutes, social homes, alcohol and drug detoxification institutions, nursing institutes, other "chronic" care institutes, and hospital departments providing the above services, even if they offer hospitalized in-patient care, provided that the insured receives services in line with the specialization of such department.

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

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

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

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

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

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

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

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

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

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

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

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

Pursuant to Clause II.1.5. of these conditions, and by way of derogation from Section 6:479. (1) of the Civil Code, the policy may be validly concluded **without the consent of the guardian authority** if the insured is a minor, or a person whose legal capacity has been partially limited in respect of making legal statements relating to property, or if the insured person is an incompetent adult.

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

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

Pursuant to Clause II.2.8 of these conditions, and by way of derogation from Section 6:443. (2) of the Civil Code, if the policy is issued with terms which differ from those of the insurance application, this difference may be contested by the policyholder without delay, or **within a maximum of 15 days.**

Pursuant to Clause II.2.9., and by way of derogation from Section 6:475. of the Civil Code, **the consent of the insured is not required for amending the insurance policy.**

Pursuant to Clause II.2.11 of these conditions, and by way of derogation from Section 6:444. (1) of the Civil Code, even if the **policyholder is not a consumer,** the policy shall be executed – by the insurance company's implicit conduct – on the terms of the application, also if the insurance company fails to respond to the insurance application within fifteen (15) days of its receipt, provided that the application was made on the insurance company's own standard application form for the type of policy in question, upon receipt of the relevant statutory information, containing the premium rates applicable.

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

X.1.3. Additional Payment Deadline

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

X.1.4. Period of Limitation

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

Schedule C
Permanent Disability Ratings

Table referred to in the Special Conditions of Permanent Partial Disability Insurance (Accidents only) and in the Special Conditions of Permanent Partial Disability Insurance (Road Accidents) for the determination of insurance benefits.

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

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

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

Effective from: September 1, 2017

Schedule D
Abstracted List of Surgeries

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

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

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

An abstracted list of surgeries by categories:

Category 1

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

Category 2

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

Category 3

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

Category 4

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

Category 5

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

Effective from: September 1, 2017

Special Conditions of Accidental Death Insurance (KBHAT/02017)

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

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

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

I. INSURED EVENT

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Special Conditions of Bone Fracture Insurance (KBCST/02017)

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

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

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

I. INSURED EVENT

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Special Conditions of Accident Expense Insurance (KBKTS/02017)

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

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

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

I. INSURED EVENT

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

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

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

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

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

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

b) the accident & injury report, if available,

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

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

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

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

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

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

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

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

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

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. INSURED EVENT

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

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

II. INSURANCE BENEFITS AND COVERED SERVICES

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

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

IV. EVENTS EXCLUDED FROM INSURANCE COVERAGE

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

IV.2. This insurance does not cover furthermore:

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

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

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