General and Special Terms and Conditions of TÖBBMILLIÓS SEGÍTSÉG Accident Insurance (TMILL23)

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Contents

Policy Conditions of ‘TöbbMilliós Segítség’ Accident Insurance (TMILL23)

These general terms and conditions (hereinafter: general conditions) and special conditions set out the standard terms and conditions for ‘**TöbbMilliós Segítség’ Accident Insurance policies** (hereinafter: **insurance policy or policy**) offered by Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the insurance policy has been concluded by reference to these general conditions and the applicable special conditions.

These general conditions shall be supplemented by the **special conditions** of the accident insurance add-on covers selected made by the policyholder on the insurance application form.

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

Provisions of the special conditions may derogate from those of the general conditions, in which cases of derogation the provisions of the special conditions shall prevail.

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

I. CONTENT OF THE INSURANCE POLICY

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

II. GENERAL PROVISIONS

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

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

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

II.1.3. **Insured** may be a natural person between the age of 0 and 79 years who is specifically designated in the insurance policy as insured and whose life or health is covered in the insurance policy with respect to specific insured events.

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

II.1.4. If the policyholder and the insured are different persons, the policyholder is required to inform the insured of all the legal statements he/she is delivered as well as of the conclusion of the insurance policy and the insured’s addition to the cover, the content and any modifications of the coverage, and the termination of the insurance policy (insured’s coverage).

II.1.5. **The insured may withdraw his/her consent to the conclusion of the insurance policy any time in a written notice. As a result, the insurance policy – or if more than one persons are insured under the policy, the coverage applicable to the particular insured, – shall terminate as of the end of the policy year, save for the case when the insured enters the policy as the new policyholder.**

II.1.6. **The insured may enter** the insurance policy **as a new policyholder**.

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

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

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

II.1.7. If both the policyholder and the insured agree in writing, a **third party** can take the insurance policy over as a **new policyholder**.

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

II.1.8. **Beneficiary** is the person entitled to receive the insurance benefits specified in the insurance policy.

a) The beneficiary of all insurance benefits **due in the life of the insured** shall be the insured himself/herself.

b) **In the event of the insured’s death**, the beneficiary of the insurance benefits shall be the person named by the policyholder and the insured as the beneficiary, or in the absence thereof, the heir of the insured.

II.1.9. **Subject to the written consent of the particular insured**, the policyholder **may designate a beneficiary** with respect to such insured person or may **modify the designation** of the beneficiary in a written statement addressed and delivered to the insurance company in accordance with the provision set out in Clause II.1.8. b), at the time when the insurance application is completed or any time throughout the whole duration of the insurance policy in the same manner, provided that such designation or modification is communicated to the insurance company prior to the occurrence of an insured event.

II.1.10. The **designation of a beneficiary shall be repealed** if the beneficiary dies or is dissolved without succession before an insured event occurs.

II.1.11. If an insurance policy is **concluded without the consent of the insured**, the **part of the insurance policy where the beneficiary is designated shall be null and void**, and the insured or the insured's heir shall be the beneficiary of the insurance who shall be required to reimburse the insurance premiums and any other costs paid on the insurance policy to the policyholder.

II.1.12. **Unless** with respect to the particular insured **a beneficiary is specifically named** in the insurance policy, or if the **designation of the beneficiary has been repealed** (Clause II.1.10) or was invalid at the time of the insured event, then the **beneficiary of the death benefit shall be the heir(s)** of the insured.

II.2. Conclusion of the Insurance Policy

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

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

II.2.3. **The insurance company will not carry out underwriting before accepting the policyholder's insurance application.** The insurance application may be accepted by the insurance company's delivering a document which certifies the insurance coverage (hereinafter: certificate of coverage) containing terms identical to or different from those specified on the insurance application, or by the insurance company's implicit conduct (tacit contract).

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

II.2.4. **If the certificate of coverage is issued** with terms that differ from those in the insurance application**, and the policyholder does not contest this difference without delay or within a maximum of 15 days, the policy shall take effect on the different terms as of the date the certificate of coverage is issued.**

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

II.2.5. **A consumer contract (insurance contract) is considered executed – by the insurance company's implicit conduct – on the terms outlined in the application if the insurance company does not respond within fifteen (15) days** of receiving the application. This is applicable provided that the application was submitted using the insurance company's standard form for the specific type of policy and included the relevant statutory information and applicable premium rates.

II.2.6. If a policy which is concluded without the express statement of the insurance company derogates in material terms from the standard insurance terms and conditions, the insurance company will have 15 days of the conclusion of the insurance policy to propose that it be modified according to the standard terms. **If the policyholder refuses the proposed modification or fails to respond to it within 15 days, the insurance company may terminate the policy giving a 30-day written notice within 15 days upon receipt of the notification of the refusal or modification.** (Subsequent termination of a contract concluded by implicit conduct [tacit contract]). In that case, however, the insurance company will refund any premium paid to the policyholder.

II.2.7. The policyholder is bound by the insurance application for 15 (fifteen) days of its date of submission.

II.2.8. The insurance plan may not be changed during the policy term.

II.3. Commencement of the insurance coverage, waiting period

II.3.1. Unless otherwise specified in these policy conditions, and if the policy is validly concluded, the insurance coverage shall commence at 0:00 a.m. on the day following the day the policyholder pays the first premium to the insurance company, but not earlier than 0:00 a.m. on the day after the contract is concluded. The parties may derogate from this provision in a separate agreement.

II.3.2. The insurance company **does not stipulate a waiting period** in the insurance policy.

II.4. Policy Term

II.4.1. This insurance policy is concluded for a fixed term.

II.4.2. The duration of the insurance policy is aligned with the age of the youngest insured among those specified in the insurance policy. However, if the policy includes insured persons belonging to the Kölyök (Kid) and Háttér (Background) and/or Y Generáció (GenY) and/or Támasz (Support) segments, the duration of the insurance policy aligns with the age of the insured who reaches the age of 25 or 80 the latest.

II.5. Termination of the insurance policy

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

a) if the premiums are not paid, in accordance with Clause IV.3 of policy conditions;
b) upon a notice of termination for convenience in respect of the entire insurance policy (Clause II.7.1);
c) upon the subsequent termination of the policy if it was concluded by implicit conduct (tacit contract) (Clause II.2.6);
d) if the insurance policy is taken out for several insured persons and all the insured persons withdraw their written consent to the conclusion of the insurance policy with effect from the end of the insurance period, except when any of the insured persons enters the insurance policy as a new policyholder.
e) if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, after the expiry of the 30-day notice period (Clause III.3.), provided that all insured persons are affected by the termination due to a change of material circumstances;

II.6. The insurance policy and the insurance coverage shall terminate (partial termination) concerning the relevant insured in any of the following cases:

a) in respect of the Y-generáció (GenY) and/or Háttér (Background), and/or Támasz (Support) segment, if the insured turns 80, with effect from the end of the particular policy period;
b) in respect of the Kölyök (Kid) segment, if the insured turns 25, with effect from the end of the particular policy period;
c) if the insured dies;
   – if the insurance does not cover the death of the particular insured, the insurance policy will terminate without a payout on the date of the death, and the excess premium will be refunded to the policyholder;
   – if the insurance covers the death of the insured, the insurance policy will terminate – subject to the provisions of the chapters (VI and VII) on exclusions and payment exemption – when the death benefit is paid out, or when the insurance claim is rejected in accordance with the policy conditions, and the insurance coverage of the particular insured will terminate with the insured's death;

d) if the insurance is cancelled for convenience in respect of the particular insured (Clause II.7.1);
e) if the insured withdraws his/her written consent to the conclusion of the insurance policy with effect from the end of the policy period, unless the insured is also the policyholder.
f) if material circumstances relevant to the insurance policy change, and the insurance company becomes aware of them, after the expiry of the 30-day notice period, in respect of the insured person concerned (Clause III.3.);

If there is only one insured party listed in the insurance policy, or if the above termination reasons apply to all insured parties, then the insurance policy shall be entirely terminated upon the occurrence of any of the termination causes specified in this section.

II.7. Termination of the insurance policy for convenience

II.7.1. The insurance policy – or if the policy is taken out to cover multiple insured persons, the insurance coverage applicable to the particular insured – **may be cancelled by the policyholder in a 30-day written notice with effect from the last day of the policy period**.

II.7.2. The insurance policy – or if the policy is taken out to cover multiple insured persons, the insurance coverage applicable to the particular insured – **may be cancelled by the policyholder in a 30-day written notice with effect from the last day of the policy period.**

II.7.3. If an insurance policy is cancelled by the policyholder for convenience, the insurance company may not reinstate the insurance coverage; in other words, the insurance policy may not be reactivated.

II.8. Geographical Limit of the Insurance Policy

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

III. RIGHTS AND OBLIGATION OF PARTIES TO THE INSURANCE POLICY

III.1. Rights and obligations of the policyholder and the insurance company

III.1.1. Pursuant to the provisions of the policy conditions, the policyholder is required to pay the insurance premium and – unless otherwise set out in the policy conditions – is entitled to make legal statements required for the insurance policy. If the insurance policy is taken out by a person other than the insured, the policyholder is required to inform the insured of all the legal statements the policyholder is delivered as well as of any modifications of the insurance policy, until an insured event occurs or until the insured enters the insurance policy.

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

III.1.3. The insurance company may require that the policyholder, insured, beneficiary/party entitled to receive the insurance benefit may appear in person before a notice delivered to the insurance company is approved.

III.2. Obligation of the policyholder and the insured to disclose information and report changes

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

III.2.1. **Obligation of the policyholder and the insured to disclose information**

In accordance with their duty to disclose information, when entering into the insurance policy or when submitting a claim under the policy, the policyholder and the insured are obliged to disclose all matters known to them or that they know to be relevant to the insurance company's decision to accept the risk or to assess the claim. By giving complete and true answers to the written questions of the insurance company, and by making true and accurate declarations on the standard forms of the insurance company and/or voice recordings, parties shall have complied with their obligation to provide information.

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

III.2.3. **The duty of the policyholder and the insured to communicate change**

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

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

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

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

III.3.1. **If the insurance company becomes aware of certain material circumstances or is informed of a change to such circumstances regarding the policy only after its conclusion, and these circumstances result in a significant increase in the insured risk, the insurance company shall be entitled, within fifteen (15) days of gaining knowledge of the new circumstances, to propose an amendment to the policy or to terminate the policy** – and, if applicable, the coverage for multiple insured persons – **by serving a written cancellation notice with a thirty (30) day notice period.**
If the insurance company fails to exercise this right, the insurance policy shall remain in force on the original terms.

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

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

IV. INSURANCE PREMIUM

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

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

IV.1.2. The insurance premium is calculated on the basis of the insurance company's Premium Rates Regulation.

IV.1.3. At the time the insurance policy is taken out, the insurance company shall determine the initial age of the insured person(s) by subtracting the insured's birth year from the year of the commencement of premium payments.

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

IV.2.1. **The insurance policy may be taken out with regular annual premium payment.** The regular annual premium applicable to the policy year **may be settled in monthly, quarterly, or semi-annual installments. In the case of choosing the postal remittance payment method, monthly and quarterly payment schedules are not available.**

IV.2.2. **The policyholder may select the payment frequency** at the time when the insurance application is completed, but he/she may request that the original frequency be modified any time during the policy term, with effect from the first day of the month following the month in which the change request is submitted.

IV.2.3. **The technical commencement of the premium payment shall be the date designated as such on the insurance application and the certificate of coverage. This date, however, may not be earlier than the first day of the month following the month when the insurance application was completed. That date shall also be the renewal date of the insurance.**

IV.2.4. **The policy period shall be one year**, each time starting on the renewal date and lasting for one year from then on (hereinafter: policy year).

IV.2.5. The first premium of the insurance policy is payable at the time specifically agreed by the parties, or failing that at the date when the insurance policy is taken out; any other premium shall be due on the first day of the respective premium payment period (year, half-year, quarter, month) which it is payable for.

IV.2.6. The first premium covers the period from the commencement of the insurance coverage to the technical commencement of premium payment as well as the first premium payment period.

IV.2.7. The policyholder will have fulfilled his/her obligation to pay the insurance premium as of the day when the insurance premium is credited to the account of the insurance company.

IV.3. Consequences of failure to pay the premium

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

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

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

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

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

IV.4. Annual Indexation

General Provisions

a) The insurance company will adjust the sum(s) insured and the insurance premium once a year to the changes in the price level (hereinafter: annual indexation). Annual indexation may be applied as of the anniversary date of the insurance policy.

b) Annual indexation is based on the indices disclosed in the Consumer Price Index publication of the Hungarian Central Statistical Office.

c) Annual indexation is the % growth based on the product of monthly consumer price indices of 12 months preceding the fourth month before the policy's insurance anniversary (hereinafter: indexation rate). If the value so calculated is less than 5%, the indexation rate shall be at least 5%.

d) The insurance company will send notification of the new sum(s) insured and the annual insurance premium of the policy applicable to the subsequent policy year at least 2 months before the policy anniversary, within the framework of the annual indexation procedure. If the policyholder does not wish to apply the amendment, he/she is entitled to refuse the indexation in writing within 30 days of receipt of the notification or, at his/her option, to terminate the insurance policy in writing with effect from the anniversary date (prior to the anniversary date) without a notice period.
If the policyholder does not expressly reject the annual indexation within 30 days, and fails to cancel the insurance policy, the insurance policy will be amended with the increased sum insured and insurance premium as of the policy anniversary.

e) The insurance company shall issue a new certificate of coverage reflecting the modified sum insured and insurance premium within 30 days of such change, unless the insurance company has already provided notice of all policy changes in the notification specified in Clause IV.4. d).

V. INSURED EVENTS, INSURANCE BENEFITS, CONDITIONS FOR PAYMENT OF INSURANCE CLAIMS, OPTIONAL FORMS AND METHOD OF CLAIMS PAYMENT

V.1. Insured events

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

V.2. Insurance benefits

If an event that is defined as an insured event in the special conditions occurs, the insurance company shall pay to the beneficiary (beneficiaries) the insurance benefit specified in the special conditions.

The insurance company will only reimburse costs which are set out in the policy conditions. Costs incurred in connection with notifying a claim are reimbursed by the insurance company only if the company expressly commits to this obligation in the special conditions.

V.3. Payment of Claims – Payment Conditions

V.3.1. **Means and Deadline of Reporting an Insured Event**

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

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

V.3.2. **Documents required for the payment of claims**

To **support an insurance claim related to any of the insured risks** covered under the policy, the insurance company may also require the following documents, if they can prove the legal basis of the claim and/or are necessary for determining the amount of the benefit:

– **a duly completed standard insurance claim form supplied by the insurance company, and**
– **the documents specified in the governing special conditions must also be submitted to the insurance company.**

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

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

V.3.2.2. **A standard form** supplied by the insurance company **and completed by the insured's treating physician or the medical facility where the insured was treated, with medical information in connection with the insured event, the insured's medical conditions, and the insured's medical history;**

V.3.2.3. 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.3.2.4. The documents **managed by the social insurance body** or another person or organization, containing data regarding the insured with respect to **the insured event or a circumstance leading to such an event** (pursuant to the entitled party's authorization for a release from the confidentiality obligation and for a request of data);

V.3.2.5. The insured's **sports club membership card** or of the membership certificate relating to any sports activities which may impact the insurance coverage, the official match report;

V.3.2.6. An official certificate in proof of the insured's date of birth;

V.3.2.7. The payment of the insurance benefit may be subject to a medical examination – in such a case, the benefit shall not be payable until the insured allows for the medical examination to be carried out.

V.3.2.8. The insurance company may also require that all documents necessary for the assessment of the insurance claim but **produced in a foreign language** shall be **translated into Hungarian** at the cost of the claimant, and the **official translations** shall be submitted to the insurance company for decision making.

V.3.2.9. The insurance company may require that **original copies of such documents** are presented and that they are also submitted on a form of electronic media chosen by the customer;

V.3.2.10. The insurance company is **entitled to obtain additional documents** for the adjustment of the insurance claim if such documents are requested within 15 days of receipt of the insurance claim and the request is communicated to the customer.

V.3.2.11. The insured or the beneficiary shall be entitled to evidence its insurance claim by other documents and receipts according to the general rules of providing evidence in order to be able to enforce such claim. For instance, the insured is also entitled to submit to the insurance company the final court decision adopted in criminal proceedings and in infringement proceedings.

V.3.3. **Due date of insurance payouts**

V.3.3.1. The insurance claim notified to the insurer shall become due on the 15th day following receipt of the last document necessary for claim settlement by the insurance company; the documents necessary for claim settlement are those which prove the ground and the amount of the insurance claim. When documents are obtained, the insurance company is required to pass a decision about the claim within 120 days after receiving the insurance claim, and shall communicate the decision to the customer.

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

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

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

V.4. Optional forms of insurance payouts, method of payment

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

VI. EXEMPTION OF THE INSURANCE COMPANY FROM CLAIMS PAYMENT

VI.1. Exemption of the insurance company from claims payment

VI.1.1. **If the policyholder or the insured infringe their duty to disclose information or communicate changes, the insurance company's obligation for benefit payment shall not set in, unless either the policyholder or the insured proves that any of the circumstances below exist:**

- **a) the concealed or undisclosed circumstance was known to the insurance company at the time the insurance policy was concluded, or**
- **b) the policyholder and/or the insured infringed their duty to communicate changes, but the concealed or unreported circumstance has come to the knowledge of the insurance company during the policy term prior to the insured event, and the insurance company failed to exercise its rights set forth in Clause III.3. of these general conditions to amend or terminate the insurance policy within 15 days, or**
- **c) the concealed or undisclosed circumstance did not contribute to the occurrence of the insured event.**

If the policy covers multiple insured persons and the obligation to disclose information and notify changes has been breached by only some of them, the insurance company shall not rely on the breach of the obligation to disclose information and notify changes with respect to the other insured persons.

VI.1.2. **The burden of proof lies with the party who alleges the existence of the listed circumstances.**

VI.2. In addition to the cases listed in Clause VI.1.1, the insurance company shall be relieved of the obligation to pay the insurance claim if

- a) **the insured died as a consequence of willful conduct by the beneficiary.**
- b) **the insurance company can prove that the event which led to the insured event was caused unlawfully and willfully or unlawfully and in gross negligence by the policyholder or by the insured; or by a relative living in the same household with them, or a company member authorized for business management**

VI.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 (duty to mitigate loss). The insured's refusal – in exercising the right of disposition to which he is entitled by virtue of law – to a medical procedure shall not constitute an infringement of the obligation to mitigate damages. The insured must act as generally expected in the given situation to prevent the occurrence of an insured event. If the Insured fails to comply with this obligation, the insurance company will be exempt from the benefit payment.**

VII. EVENTS EXCLUDED FROM INSURANCE COVERAGE

VII.1. **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, terrorist acts, workplace disorder, border conflicts, insurrection.**

VII.2. **For the purposes of these general conditions, an act of terrorism shall, in particular, mean any act of violence, threat of violence endangering human life, material or immaterial property or infrastructure, which either advocates political, religious, ideological or ethnic aims or is intended or likely to influence a government or to create fear in a society or a section of it, or which are suitable for the above.**

VII.3. **Notwithstanding the provisions set forth in Clause VII.1. d) of these general conditions, 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.4. **The insurance company shall not be liable for events arising out of or caused in whole or in part by the events listed hereunder:**

- **a) such illness or pathological condition of the insured that has been proven to have existed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any disease that had been diagnosed during any time in the 3 (three) years prior to the commencement of the insurance coverage, or any illness that required treatment or medical control during this time period,**
- **b) the permanent health impairment of the insured diagnosed prior to the commencement of the coverage period.**

VII.5. **The insurance does not cover the events which take place while the insurance policy is in force (during the coverage period), if**

- **a) The event occurred in connection with the insured's regular alcohol consumption, drug use, or the intake of stupefying agents or pharmaceuticals, unless such substances were administered as prescribed by the treating physician and in accordance with the instructions;**
- **b) the insured was verifiably under the influence of alcohol or drugs, stupefying agents or medication at the time of the event. If a blood alcohol test is administered, the person is considered to be 'under the influence of alcohol' for the purposes of this paragraph if their blood alcohol concentration exceeds 1.5‰, or 0.8‰ while driving a motor vehicle.**

c) **the Insured was driving a motor vehicle without a valid vehicle registration certificate or without a valid driver's license required for driving such vehicle, while at the same time also committed other traffic violations;**
d) **the insured was driving a motor vehicle under the influence of alcohol when the insured event occurred and at the same time also committed other traffic violations.**

VII.6. The insurance does not cover events caused in whole or in part by:
a) **hospital care that is not for diagnosing the insured's disease, preventing further deterioration of their medical condition, or restoring their health – such as screening tests, a parent's stay at the hospital with their child, or the insured's stay for 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 for the purpose of diagnosing chronic illness, initiation of a therapy, the prevention of significant deterioration of acute conditions,**
c) **treatment performed by a person who does not have medical certification and a permit to practice medicine,**

VII.7. The insurance does not cover psychological disorders and/or psychiatric conditions, suicides, suicide attempts, or physical injuries deliberately inflicted by the insured on themselves, even if the insured was mentally disturbed at the time of the incident.

VII.8. The insurance does not cover events that may have been directly caused by the insured's participation in or pursuit of the following sports activities:

scuba diving to a maximum depth of 40 metres, singlehanded and open sea sailing, white water rafting, riverboarding (hydrospeed), canyoning, surfing, mountaineering and rock-climbing on routes graded 5 or higher, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, motocross sport, motorboat sports, motorcycle sports, rally, ability competitions by car), quad biking, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hang-gliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping).

VII.9. If the insured has reached their 18th birthday at the time of the insured event, then the insurance shall no longer cover those events which are causally linked to the insured's participation in professional or competitive sports activities.

VII.10. The insurance does not cover events which may have been directly caused by the insured's engagement in or pursue of the following occupations or job activities:

stuntmen, circus artists, equilibrists, test pilots, flight test pilots, parachute jumpers, jet plane crew in the army, bodyguards, commando staff, foreign legionnaires, peacekeepers, secret agents, armed guards, armored car personnel, specialists or officers serving in the army who are exposed to high levels of risks during their activities (e.g. bomb experts, divers, commandos).

VIII. MISCELLANEOUS PROVISIONS

VIII.1. Period of limitation

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

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

VIII.2. Loss or destruction of the certificate of coverage

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

VIII.3. Disputes Resolution Procedure

If the customer disputes the position of the insurance company in connection with a claim for an insurance benefit, he/she may file a written request a review of the decision.

The review shall be carried out by the competent organizational unit of the insurance company within 30 days upon receipt of all documents/data necessary for the assessment of the request and the decision shall be communicated to the claimant.

IX. GLOSSARY OF TERMS

IX.1. Accident

IX.1.1. For the purposes of these general conditions, an **accident** means a sudden, one-time external physical and/or chemical impact beyond the insured's control during the coverage period, resulting in the insured suffering permanent health impairment or death.

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

c) tetanus infection, if the illness has been diagnosed, and has appeared no sooner than a minimum of 20 days after the commencement of the coverage, or no later than a maximum of 20 days after the expiration of the coverage. The onset of the illness shall be 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 and notwithstanding the provisions set out in Clause IX.1.2, **accident does not mean**:

a) infection by infectious agents (bacteria, virus, protozoa) from human or animal primary-host (carrier) to a human body secondary-host (receiver) which infection occurred directly or indirectly (hereinafter together: transmission), not even in the event that the transmission occurred as result of an accidental physical cause, unless the special conditions stipulate this otherwise,
b) occupational disease (harm),
c) the insured's suicide or suicide attempt, even if the insured was mentally incompetent at the time of the incident,
d) pathologic fractures, repeated (habitual) dislocation,
e) development of disc herniation, unless the disc herniation is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy disc,
f) development of abdominal hernia, unless the abdominal hernia is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy abdominal-wall,
g) damage to the articular joints, tendons, other soft-tissues, unless the damage is the result of a one-time, extreme, exterior, direct mechanical impact to an otherwise healthy joint.

IX.2. Illness

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

IX.3. Hospital

IX.3.1 For the purposes of these general conditions **hospital** means institutions which provide licensed in-patient care recognized by the professional supervisory body, and operate under permanent medical supervision and control.

IX.3.2 For the purposes of these general conditions, **hospital does not mean** sanatoriums, rehabilitation centers, thermal or hydromineral establishments, psychiatric hospitals or psychiatric wards, geriatric nursing institutes, social homes, alcohol and drug detoxification institutions, nursing institutes, other "chronic" care facilities, and hospital departments providing the above services, even if they offer hospitalized in-patient care, provided that the insured receives services in line with the specialization of such department.

IX.4. Surgery and the List of Surgeries

IX.4.1. For the purposes of the present general terms and conditions, the term surgery shall refer to medical procedures which involve an incision of the integument and/or the mucous tissue for preserving health, healing diseases and injuries, and mitigating the consequences of the above, governed by the principle of medical practice.

IX.4.2. The insurance company classifies surgical procedures into groups (hereinafter: classification of surgeries). This classification of surgical procedures, along with the applicable insurance benefit rates (hereinafter: the List of Surgeries), is detailed in Annex 'A' to these General Conditions.
All WHO-coded surgical procedures were assessed by the insurance company for surgical reimbursement, with surgical procedures not included in any of the groups in the Surgical List falling into the "non-covered" surgical reimbursement category 5 (e.g. diagnostic tests, procedures including histological sampling, cytology, injection-infusion treatments, physiotherapy, chemotherapy).

IX.5. Qualification of the insured's sports activities

IX.5.1. For the purposes of these conditions the insured shall qualify as a **professional athlete** if he/she entered into employment or other work-related legal relation with a sports association, or is engaged in sports activities under a sports contract, or is licensed as a professional athlete by a foreign sports federation.

IX.5.2. For the purposes of these general conditions, a **competitive athlete** is an insured (hereinafter: competitive athlete) who performs a sport activity as a non-professional athlete, provided that he/she also competes in a competition (championship, match), regardless of the nature of the competition (e.g. whether it is local, district, county, regional, national, international, etc. or whether it is a friendly competition or for a prize, etc.).

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

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

IX.5.3. For the purposes of these general conditions the insured shall qualify as a **recreational athlete** if he/she does not perform sports activities as a professional athlete or a competitive athlete.

X. PROVISIONS WHICH MATERIALLY DIFFER FROM THE PROVISIONS OF THE HUNGARIAN CIVIL CODE OR STANDARD CONTRACTUAL PRACTICE

This chapter summarizes the provisions of the General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance that materially differ from the relevant provisions of Act V of 2013 on the Hungarian Civil Code (hereinafter: the Civil Code) or from standard contractual practice.

X.1. Provisions that materially differ from the provisions of the Hungarian Civil Code or standard contractual practice

X.1.1. **Conclusion of the Insurance Policy**

Pursuant to Clause II.2.4 of these policy conditions, and by way of derogation from Section 6:443 (2) of the Civil Code, if the certificate of coverage is issued with terms which differ from those of the insurance application, this difference may be contested by the policyholder without delay, or within a maximum of 15 days.

X.1.2. **Additional Payment Deadline, Reactivation Option**

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

Pursuant to Clause IV.3.3. of these policy conditions, and by way of derogation from Section 6:449 (2) of the Civil Code, the policyholder may request the reinstatement of the insurance cover under a contract which has been terminated without benefit payout due to non-payment of premiums within 6 months.

X.1.3. **Period of Limitation**

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

Annex No. 1

Permanent Health Impairment Rates

Applicable to *TöbbMilliós Segítség* Accident Insurance (TMILL23)

The table referred to in the special conditions of accident-related permanent health impairment insurance to be used for determining the insurance benefit.

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

The extent of the permanent health impairment underlying the insurance claim shall be established by the insurance company's physician-expert in accordance with the following:

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

Annex No. 2

Classification of Surgical Groups into Surgical Benefit Categories

for TöbbMilliós Segítség Accident Insurance (TMILL23)

List of surgical procedures by reimbursement category and the percentage of the sum insured reimbursed:

for surgeries in Category 1, 100% of the sum insured,

- open surgeries involving the brain/spinal cord
- open heart surgeries
- organ transplantations

for surgeries in Category 2, 50% of the sum insured,

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

for surgeries in Category 3, 25% of the sum insured,

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

for surgeries in Category 4, 15% of the sum insured.

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

surgeries in Category 5 are not covered.

- laser vision correction corneal surgery
- vascular catheterisation for diagnostic purposes
- treatment of injuries to the skin and mucous membranes and subcutaneous tissues (e.g. sutures, removal of nerve tissue)
- surgical removal of lesions of the skin, mucous membranes and subcutaneous connective tissue (e.g. moles, warts, lipomas)
- removal of foreign bodies from open body cavities (e.g. alimentary canal, nose, trachea, bronchus, bladder, vagina) and from the eye
- endoscopic procedures (e.g. otoscopy, rhynoscopy, bronchoscopy, gastroscopy, colonoscopy, cystoscopy, ureteroscopy, colposcopy, hysteroscopy, etc.) for diagnostic purposes, with or without histological sampling
- arthroscopy for diagnostic purposes
- dental procedures
- procedures and surgeries for aesthetic purposes only
- procedures and surgeries related to infertility, pregnancy, childbirth
- percutaneous histological sampling, punctio, drain from any organ except the brain

Special Conditions of Accidental Death Cover

These special accident insurance conditions set out the standard terms and conditions for **the accidental death cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) that occurs during the coverage period and results in the insured's death within one year of the accident.

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

II. INSURANCE BENEFITS

If an insured event specified in the insurance policy occurs, the **sum insured applicable to this risk, as specified in the certificate of coverage or indexation letter in effect at the time of death** – i.e., the last in force following the termination of the insurance policy – **shall be paid to the entitled beneficiary**, and the insurance policy shall then terminate.

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 on the last certificate of coverage in force or in the last indexation letter**.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** after the occurrence of the death.

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits**.

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

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

a) the postmortem certificate,
b) hospital course of the deceased,
c) the autopsy report, if one was made;
d) the insured's certificate of death,
e) all medical documents produced in connection with the insured event from the occurrence of the accident until filing the insurance claim, in particular the medical documentation of the first medical care,
f) the accident & injury / workplace A&I / police report, if one was made,
g) the results of the blood alcohol test and/or drug test, if administered,
h) in the case of a road traffic accident, in addition to the above
   – if the **insured is injured** in a road traffic accident as **the driver of a motor vehicle**, a copy of the vehicle registration certificate,
i) **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,

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

In the case of this insurance policy, the insurance company will be exempted of payment of the death benefit (accidents) in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of the Accident-Related Permanent Health Impairment Cover

These special accident insurance conditions set out the standard terms and conditions for the **accident-related permanent health impairment insurance coverage available for 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In all other respects, the provisions of the **Hungarian Civil Code** and other **applicable Hungarian laws** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

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

I.2. **Health impairment** shall mean the **loss of any physical and/or mental function** that **restricts the individual's normal conduct**.

I.3 **Impairment shall be permanent** if the **medical condition of the insured is unchanging, stable**. If the extent of the health impairment is **still continuously changing but two years have elapsed** since the date of the accident, the **insurance company's medical expert shall determine the verified extent of residual health impairment**. The insurance company shall regard **this impairment as permanent** for the purposes of its payment obligations and the calculation of the benefit, based on the consequences of the accident. When assessing permanent health impairment, **no consideration shall be given to changes in the insured's capacity for work or to restrictions on participating in sports activities**. No **adverse aesthetic effect** or other (social, financial, or otherwise) **detriment caused by the accident** shall, in itself, **constitute grounds for an insurance claim** for permanent health impairment.

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

II. INSURANCE BENEFITS

II.1. **If the insured event specified in Clause 1.1 occurs, the insurance company will pay the benefit based on the sum insured for this risk as stated in the certificate of coverage effective at the time the health impairment was confirmed, or, if the policy had been terminated, in the last effective certificate of coverage or in the indexation letter, in accordance with the following.**

- If the extent of the insured's health impairment (within the meaning of Clause I.3 of these special conditions) is between 1% and 10%, the insurance pays the beneficiary the sum insured specified in the insurance plan selected for the insured.
- If the extent of the insured's health impairment (within the meaning of Clause I.3 of these special conditions) exceeds 10%, the insurance pays the beneficiary a percentage of the sum insured corresponding to the range of accident-related permanent health impairment applicable to the insured (11%–50% or 51%–100%), as specified in the selected insurance plan, which reflects the extent of their accidental permanent health impairment.

II.2. **The extent (degree) of the permanent health impairment** on which the insurance claim is based **shall be confirmed by the insurance company's medical expert, in accordance with the table in Schedule No. 1, which shall form an integral part of the general conditions.**

II.3. If the extent of the health impairment **cannot be established on the basis of the table,** the insurance benefit shall be determined by a **medical assessment 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 disability determined by the opinion of the **National Institute of Medical Experts** (or the body authorized by applicable legislation to establish the degree of disability or health impairment) and/or by the resolution of the National Pension Insurance Administration **shall not be binding** on the insurance company's medical expert when determining the extent of disability or the amount of benefits payable by the insurance company. **Furthermore, no expert opinion or resolution issued by any other medical expert board shall be binding** on the insurance company in determining the permanent nature of the health impairment or its extent.

II.4. **The extent of the permanent health impairment** resulting from any one insured event **may not exceed 100%.**

II.5. **If the insured dies before their health impairment could become permanent, the benefit shall be determined on the basis of the extent of impairment confirmed by the insurance company's medical examiner on the basis of the documents of the last medical examination.**

II.6. **No insurance claims** for permanent health impairment **shall be accepted if the insured dies within 15 days after the accident.**

II.7. **If the insurance company has already established that the claim** for a benefit **is grounded but the benefit amount cannot be determined yet, the insured may require the insurance company to pay a minimum amount due under the given cover.**

II.8. **If the insurance company has already paid a benefit and the insured's condition subsequently worsens due to the same insured event, the insured may submit a supplementary claim once a year for up to two years from the date of the initial accident reported in the first claim.** This claim must be supported by all necessary medical documents demonstrating the deterioration despite appropriate treatment, and the insured may request a reassessment of their condition and a new determination of the extent of permanent health impairment. 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 any benefit payouts made earlier on the insured event referred to above **shall be deducted from any later benefit payout**.

Even in such cases, the extent of permanent health impairment resulting from the same insured event **shall not exceed 100%.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where the **above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

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

a) all medical documents related to the insured event from its occurrence until the notification of the insurance claim,
b) the accident & injury report / the workplace accident & injury report, if one was made,
c) the results of the blood alcohol test and/or drug test, if administered,
d) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is injured in a road traffic accident as the **driver of a motor vehicle**, a copy of the vehicle registration certificate,
e) other documents required to clarify the circumstances of the accident.

III.4. **In addition to the above, the insurance company may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions** – for the assessment of the insurance 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 reject the insurance claim on the basis of the findings of such review.

III.6. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 insurance benefit is claimed on a permanent health impairment which 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 health impairment is confirmed to be permanent, or within 15 days after the expiry of 2 years following the accident.

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

For this insurance policy, the insurance company shall be relieved of the obligation to pay the accident-related permanent health impairment benefit in the cases described in Chapter VI of the general conditions, and the policy does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Bone Fracture and Tooth Fracture Cover

These special accident insurance conditions specify the standard terms and conditions for **coverage of bone fractures and tooth fractures under insurance policies** offered by Generali Biztosító Zrt. (hereinafter: the insurance company), provided that the policy has been concluded with reference to these special conditions.

In the case of **matters not regulated by these special conditions**, the insurance shall be governed by and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) that occurs during the coverage period and **results in the insured suffering a bone fracture, including fissure fractures, or the fracture of a permanent tooth**.

I.2. For the purposes of these policy conditions, the fracture of a permanent tooth shall refer to incidents in which the crown of an otherwise undamaged, healthy tooth with intact enamel is fractured, as evidenced by a dental X-ray, and the fracture involves at least half of the tooth above the gum line.

The insurance coverage shall not apply to mild chipping of a permanent tooth or only of its edge, or any broken tooth which is not the result of an accident.

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

II. INSURANCE BENEFITS

If the insured event defined in the insurance policy occurs, **the insurance company will pay the benefit per accident – irrespective of the number of fractures – based on the sum insured stated in respect of this insured risk in the certificate of coverage effective** as of the date of the accident**, or in the indexation letter.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where the **above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**

a) the x-ray or medical findings confirming the bone fracture, the fissure fracture or the fracture of a permanent tooth,
b) all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
c) the accident & injury report, or the workplace accident & injury report, if one was made,
d) the results of the blood alcohol test and/or drug test, if administered,
e) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is **injured in a road traffic accident as the driver of a motor vehicle**, a copy of 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.3.2. of the general conditions – for the assessment of the insurance 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 reject the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

In the case of this insurance policy, the insurance company will be relieved from the payment of the bone fracture benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Soft Tissue Injuries Cover

These special accident insurance conditions set out the standard terms and conditions for the **soft tissue injuries cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance policy has been concluded by reference to these policy conditions.

In the case of **matters not regulated by these special conditions**, the insurance shall be governed by and subject to **the General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the Hungarian Civil Code and other effective Hungarian regulations shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) which occurs during the coverage period and **as a result of which the Insured suffers any of the following:**

a) **dislocation**: the position of the two bones forming the shoulder, elbow, wrist, hip, knee, or ankle joint that deviates from their normal anatomical position and does not return to the original position either spontaneously or through external intervention before documented by imaging. For the purposes of these special conditions, joint dislocation does not include
   – repeated (recurrent) dislocations, or
   – the dislocation of any body part which has been dislocated before the commencement of the insurance coverage.

b) **ligament rupture**: a ligament injury (tear) in a joint confirmed by an MR or any other medical document and an operative report, where the injured joint requires surgical repair (ligament suture or substitution) within a week from the date of the accident or where the joint is immobilized for at least four weeks (plaster cast or immobile plastic brace).

c) **muscle tear**: an injury of a muscle or tendon to an extent that it requires surgical repair within one week of the date of the accident.

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

II. INSURANCE CLAIMS AND LIMITATIONS TO CLAIMS PAYMENT

II.1. **If the insured event occurs, the insurance company shall pay the benefit per accident – regardless of the number of occurrences specified in Clause 1.1 of these special conditions – based on the sum insured for this risk as stated in the effective certificate of coverage, or if the policy had been terminated, in the last valid certificate of coverage or in the indexation letter.**

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where the above time limit is not observed and as a result material conditions or circumstances may not be revealed, the insurance company may be relieved of payment of insurance benefits/proceeds.

III.3. Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.

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

III.3.2. and copies of the following documents:

a) the following must always be submitted:
   – all medical documents produced in connection with the insured event from the occurrence of the accident until filing the insurance claim, in particular the medical documentation of the first medical care,
   – the accident & injury report / the workplace accident & injury report, if one was made,
   – the results of the blood alcohol test and/or drug test, if administered,
   – in the case of a **road traffic accident**, in addition to the above:
      i. the police report, if one was prepared,
      ii. if the insured is injured in a road traffic accident as the **driver of a motor vehicle**, a copy of the vehicle registration certificate,
   – other documents required to clarify the circumstances of the accident.

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

c) in the event of ligament rupture:
   – the diagnostic report of an MR scan, if one was made,
   – the hospital discharge summary if a surgery was performed, specifying the surgical procedure performed, its date and its description (operative report),
   – if the joint is immobilized by a plaster cast or a brace, the physician's statement produced when it is removed,

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

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions – for the assessment of the insurance 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 reject the insurance claim on the basis of the findings of such review**.

III.6. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

In the case of this insurance policy, the insurance company will be relieved of payment of the soft tissue injury benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Accident Related Hospitalization Cover with Daily Payment

These special accident insurance conditions set out the standard terms and conditions for the **accident-related hospitalization cover with daily allowance of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and **other effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) **that occurs during the coverage period** and **results in the insured receiving continuous inpatient hospital care** (within the meaning of Clause IX.3 of the general conditions), provided that such hospital care is medically necessary.

I.2. For the purposes of this insurance, the person receives **inpatient hospital care** if such person is admitted to and stays in a hospital for multiple (more than one) days to receive medical care, and **spends every night of his/her hospitalization between the day of admission and the day of discharge** in such institution **in connection with the medical treatment**. The insured is hospitalized for more than one 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

II.1. The insurance company will pay an insurance benefit for **each day of the insured's inpatient hospital care** (within the meaning of Clause I.2. of the special conditions) **which is required to treat** the medical consequences of the accident **any time within two years after the date of the insured's accident**.

II.2. **The benefit amount payable for the insured's inpatient hospital care shall be calculated as the sum insured specified in the certificate of coverage or indexation letter** in effect during the hospitalization period**, multiplied by the number of days of hospitalization.**

If the insured suffers an accident while the insurance policy is in force but **receives inpatient hospital care related to such accident only after the termination of this insurance policy**, the benefit payout will be determined – after the insurance policy was terminated – on the basis of the **sum insured stated in respect of this insured risk in the last effective certificate of coverage or in the last indexation letter.**

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, determined in accordance with Clauses II.2 and II.4 of these special conditions, 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 subintensive care unit (SICU) or in a post-anesthesia care unit (PACU) does not qualify as treatment in an intensive care unit (ICU).

II.4. **If** the anniversary date of the insurance policy falls during a period when the insured is hospitalized inpatient, and **the policy is subject to annual indexation** (as defined in Clause IV.4. of the general conditions), the insurance company shall **apply the increased sum insured**, in accordance with the rules of annual indexation, to determine the benefit payout **after the policy anniversary**.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** after the end of the hospital care.

III.2. Where the **above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**

a) the hospital discharge summary,
b) the discharge summary issued by the intensive care unit, if such treatment was provided,
c) all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
d) the accident & injury report, or the workplace accident & injury report, if one was made;
e) the results of the blood alcohol test and/or drug test, if administered,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is injured in a road traffic accident as the **driver of a motor vehicle**, a copy of 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.3.2. of the general conditions** – for the assessment of the insurance 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 provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

Under this insurance policy, the insurance company will be relieved from the payment of the accident-related hospitalization daily allowance in the cases described in Chapter VI of the general conditions, and the insurance does not offer coverage for the cases listed in Chapter VII of the general conditions.

Special Conditions of Accident Related Surgery Cover

These special accident insurance conditions set out the standard terms and conditions for the **accident-related surgery insurance cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and **other effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1. of the general conditions) that occurs during the coverage period and results in the insured undergoing surgery (within the meaning of Clause IX.4. of the general conditions), provided that the surgery is medically necessary. I.2. The date of the insured event is the date of the accident.

II. INSURANCE BENEFITS

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

II.2. The insurance benefit is a **percentage of the sum insured stated in respect of this insured risk in the certificate of coverage effective as of the date of the surgery or in the indexation letter, corresponding to the category of the surgical procedure performed**. If the surgery is **performed after the termination of this insurance policy but within two years after the date of the accident** specified as the insured event, the insurance benefit payout will be determined – after the termination of the insurance policy – on the basis of the **sum insured specified in respect of this risk in the last certificate of coverage in force or in the indexation letter.**

II.3. The classification of operations is set out in the List of Surgeries in Schedule No. 2 to the general conditions. The List of Surgeries is a classification of surgical groups by reimbursement category. The List of Surgeries shall also indicate the % rates of benefits.

II.4. **If multiple surgeries are performed on the same day or during the same procedure**, the insurance company shall **determine the benefit based on the surgery with the lowest category number** (i.e., **the highest percentage of benefit payment**).

II.5. The insurance company's benefit payment on any one insured event shall be limited to 100% of the sum insured, with the exception of the benefit specified in Clause II.6 of these special conditions.

II.6. **In addition to the surgery benefits defined above, the insurance also pays extra benefits related to plastic surgeries.**

If the insured, in relation to an accident within the meaning of Clause I.1 of these special conditions, sustains

a) third-degree burns covering at least 20% of the total body surface area, or burns covering at least 2% of the total body surface area on the face (including the ears) and the neck beneath the chin, the insurance company shall pay 100% of the sum insured determined in accordance with Chapter II of these special conditions.
b) extensive severe skin abrasions, involving tissue loss of the epidermis due to friction and/or tearing of the skin to the subcutaneous layer, in full thickness on at least 5% of the total body surface, or on the face (including the ears), and the neck under the chin area, covering in full thickness at least 2% of the total body surface, the insurance company will pay 100% of the sum insured determined in accordance with Chapter II of these special conditions.
c) injuries which require a bone graft on the insured's face, the insurance company will pay 100% of the sum insured determined in accordance with Chapter II of these special conditions.

II.7. For the purposes of these policy conditions, plastic surgery only means surgeries which aim at restoring or reconstructing the appearance of the human body (to the original or largely resembling form). Surgeries performed with the only aim to treat or reconstruct a function shall not be considered plastic surgeries.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** of the surgery.

III.2. Where the **above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits**.

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**

a) the hospital discharge summary,
b) the surgical documentation, if any was made,
c) all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim, d) the accident & injury report, or the workplace accident & injury report, if one was made;
e) the results of the blood alcohol test and/or drug test, if administered,
f) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is injured in a road traffic accident as **the driver of a motor vehicle**, a copy of the vehicle registration certificate.

III.3.3. **If a plastic surgery is performed, copies of the following documents shall also be submitted:**

a) the medical document confirming the necessity of the plastic surgery,
b) medical documents describing the insured's permanent conditions (e.g.: the extent and size of the damage) produced directly before the plastic surgery is performed,
c) the operative report and medical documentation prepared in connection with the plastic surgery,
d) the surgical documentation of the plastics surgery, if any was made.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions** – for the assessment of the insurance 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 provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

In the case of this insurance policy, the insurance company will be relieved from the payment of the surgery benefit (accidents) in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Burn Injury Cover

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

In the case of **matters not regulated by these special conditions**, the insurance shall be governed by and shall be subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) that occurs during the coverage period **and results in the insured suffering burn injuries.**

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

II. INSURANCE BENEFITS

II.1. The **insurance company shall pay the % of the sum insured stated in respect of this insured risk in the certificate of coverage effective** as at the date of the insured event, or in the effective indexation letter, **corresponding to the severity of the burns**.

II.2. **The benefit is calculated as a percentage of the sum insured, based on the degree of burns and the affected body surface area, as specified in the table.**

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

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

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

II.6. **If evidence shows that the insured's death was directly caused by burns**, the insurance company shall **pay the death beneficiary 200% of the sum insured**, regardless of the severity of the burns.

II.7. **The insurance company's benefit payment for claims made on any one insured event shall be limited to 200% of the sum insured stated for this insured risk.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**

a) a copy of the hospital discharge report or the outpatient record, 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 its occurrence until the notification of the insurance claim,
c) the accident & injury report, or the workplace accident & injury report, if one was made,
d) the results of the blood alcohol test and/or drug test, if administered,
e) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is injured in a road traffic accident as **the driver of a motor vehicle**, a copy of the vehicle registration certificate.

III.4. **In the event of death, copies of the following documents shall also be submitted with the claim:**

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

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

III.5. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions** – for the assessment of the insurance claim.

III.6. **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 reject the insurance claim on the basis of the findings of such review.**

III.7. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

Under this insurance policy, the insurance company will be exempted from the payment of the burn injury benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of the Accident Expenses Cover

These special accident insurance conditions set out the standard terms and conditions for the **reimbursement of accident expenses cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) that occurs during the coverage period and **results in the insured incurring accident-related expenses, as defined in Clause I.2 of these special conditions.**

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

a) **rescue costs** necessarily incurred if the insured has suffered an accident and is injured, and as a result needs to be rescued, or the insured dies in the accident, and the body can only be reached through rescue manoeuvers,

b) **transport costs** necessarily incurred when the insured person is transported from the place of the accident to the nearest hospital or doctor's surgery suitable for treatment, and once home from the healthcare provider on medical advice, or if the insured person dies as a result of the accident and when his/her body is transported from the place of the accident (the insurance company does not cover the transport of the insured person for dressing, stitching or other medical examinations),

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 mean 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 durable 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.

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

I.3. Accident expenses shall not include travel and accommodation costs related to bath therapies and vacations.

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

II. INSURANCE CLAIMS AND LIMITATIONS TO CLAIMS PAYMENT

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

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

b) expenses incurred within one (1) year of the date of the accident in respect of point e) of Clause I.2 of these special conditions,

if these costs are not recovered in any other way.

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

II.3. **In respect of any one insured event, the insurance company's payment to the beneficiary shall be limited to the sum insured stated in the certificate of coverage effective as of the date of the insured event – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation letter.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** of the date of the invoice.

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits**.

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

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

III.3.3. **and copies of the following documents:**

a) all medical documents related to the insured event from its occurrence until the notification of the insurance claim,

b) the accident & injury report / the workplace accident & injury report, if one was made,

c) the results of the blood alcohol test and/or drug test, if administered,

d) in the case of a road traffic accident, in addition to the above:
   – the police report, if one was prepared,
   – if the insured is injured in a road traffic accident as **the driver of a motor vehicle**, a copy of the vehicle registration certificate,
e) other documents required to clarify the circumstances of the accident.

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

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

Under this insurance policy, the insurance company will be exempted from the payment of the accident expense benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of the Reimbursement of the Costs of a Wheelchair

These special accident insurance conditions set out the standard terms and conditions for the **reimbursement of the costs of a wheelchair under an insurance policy** 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) that **results in a form of health impairment specified in Clause I.2 of these special conditions, and in which the insured's condition renders a wheelchair medically necessary on a permanent basis.**

Health impairment shall be permanent if the medical condition of the insured is unchanging, stable. 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.

I.2. **The accident shall only be considered an insured event if as a result**
- **a) the insured permanently loses motor function (paralyzed) in the lower extremities, or**
- **b) the motor function in the insured's lower extremities is so severely impaired (paraparesis) that he/she cannot walk, not even with a frame, or**
- **c) the insured lost both legs as a result of an amputation, and he/she is not suitable for prosthetic legs.**

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

II. INSURANCE BENEFITS

The insurance company shall reimburse the costs of a wheelchair, evidenced by an invoice, up to the sum insured stated in respect of this insured risk in the certificate of coverage effective as of the date of the accident – or if the insurance policy had been terminated, in the last effective certificate of coverage – or in the indexation letter, provided that the wheelchair is necessary within 2 years following the date of the accident, and its costs cannot be otherwise recovered.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** of the date of the invoice.

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **a written prescription from a specialist authorized to prescribe durable medical equipment, along with the corresponding medical recommendation,**

III.3.3. **original invoices** issued to the name of the insured, certifying payments,

III.3.4. **and copies of the following documents:**
- a) all medical documents related to the insured event from its occurrence until the notification of the insurance claim,
- b) the accident & injury report / the workplace accident & injury report, if one was made,
- c) the results of the blood alcohol test and/or drug test, if administered,
- d) in the case of a road traffic accident, in addition to the above:
  - the police report, if one was prepared,
  - if the insured is injured in a road traffic accident as **the driver of a motor vehicle**, a copy of the vehicle registration certificate,
- e) other documents required to clarify the circumstances of the accident.

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions** – for the assessment of the insurance 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 reject the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

Under this insurance policy, the insurance company will be relieved from the reimbursement of the costs of a wheelchair in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Tick Bite Related Neuropathy Cover

These special accident insurance conditions set out the standard terms and conditions for the **tick bite related neuropathy cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The insured event is an **accident** – within the meaning of this clause – which the insured suffered during the coverage period, and which **results in the insured's permanent neuropathy** (damage to sensory or motor nerves) developed at least one month following the end of the medical treatment.

I.2. For the purposes of these policy conditions, **the end of the medical treatment shall be the day** after which the insured **no longer needs follow-up examinations** for the active treatment of the disease, as evidenced by the documentation issued by the treating physician or treating provider.

I.3 **For the purposes of Clause I.1 of these Special Conditions, an accident shall mean encephalitis, meningitis, or Lyme disease caused by the bite of an infected tick.**

I.4. **Meningitis and/or encephalitis develops as a result of a tick bite** if the illness has been serologically confirmed and manifests at the earliest at least 15 days after the effective date of the insurance coverage, and at the latest within a maximum of 15 days after the termination of the insurance policy. For the purposes of this paragraph, the date of the insured event is the day when the insured has turned to a physician due to the onset of the illness diagnosed as meningitis and/or encephalitis.

I.5. **Lyme disease develops as a result of a tick bite** if the illness has been serologically confirmed and the characteristic skin condition has appeared at the earliest at least 2 days after the effective date of the insurance coverage, and at the latest within a maximum of 15 days after the termination of the insurance policy. In cases where the characteristic bull's-eye rash has not developed, the limitation on the latest date of the latent period shall not apply, but the date of the serological blood test results may not be later than the last day of the insured period. For the purposes of this paragraph, **the date of the insured event:** the day when a serological blood test is ordered for the diagnostic identification of Lyme-disease, if the insured is then diagnosed with Lyme-disease.

II. INSURANCE BENEFITS

The insurance company will pay out the sum insured stated in respect of the insured risk in the certificate of coverage effective as of the date of the insured event, or in the indexation letter.

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**

a) for tick-borne meningitis and/or encephalitis a copy of the result of the serological blood test,
b) for tick-borne Lyme-disease the positive result of the serological blood test, as well as the medical document ordering a serological blood test for the diagnostic confirmation of Lyme-disease,
c) the copies of all medical documents produced from the time of the first treatment until notifying the insurance claim,
d) the medical documents in proof of ending the treatment,
e) the medical documents describing the insured's condition after the end of the treatment.

III.4. In addition to the above, the insurance company may request or obtain additional certifications or statements – **listed in Clause V.3.2. of the general conditions – for the assessment of the insurance 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 reject the insurance claim on the basis of the findings of such review.**

III.6. **The insurance company may provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

For this insurance policy, the insurance company shall be relieved of payment for benefits related to tick bite-associated neuropathy in the cases described in Chapter VI of the general conditions, and the policy does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Special Surgeries Cover

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

In the case of **matters not regulated by these special conditions**, the insurance shall be governed by and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and other **effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. INSURED EVENT

I.1. The **insured event is a surgery defined in Clause I.2 of these special conditions performed** on the insured during the coverage period.

I.2. **For the purposes of these special conditions, surgeries include only the following procedures:**

a) **surgical correction of inguinal hernia (herniorrhaphy or hernioplasty)**
b) **appendectomy,**
c) **tonsillectomy.**

I.3 **The date of the insured event shall be the date of the surgery.**

II. INSURANCE CLAIMS AND LIMITATIONS TO CLAIMS PAYMENT

II.1. **If an insured event occurs, the insurance company shall pay the sum insured stated in respect of this insured risk in the effective certificate of coverage or in the indexation letter.**

II.2. **In any one policy year, the insurance company will pay out only once – to the same insured – on insured events related to this insured risk.**

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim must be notified to the insurance company **within 15 days** after the end of the hospital care.

III.2. Where **the above time limit is not observed** and as a result material conditions or circumstances may not be revealed, **the insurance company may be relieved of payment of insurance benefits.**

III.3. **Following the notification of an insurance claim, the insurance company may, in addition to the documents listed in Clause V.3.2 of the general conditions applicable to the policy, also require the submission of copies of the following documents if they are necessary for verifying the legal basis of the claim or the benefit amount.**

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

III.3.2. **and copies of the following documents:**
a) all medical documents produced in connection with the insured event from the first treatment until the notification of the insurance claim,
b) the hospital discharge summary,
c) a copy of the operative report, if one was made,

III.4. In addition to the above, the insurance company **may request or obtain additional certifications or statements – listed in Clause V.3.2. of the general conditions** – for the assessment of the insurance 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 provide for the payment of the insurance benefit to be subject to a medical examination – in such a case, the insurance benefit 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 FROM COVERAGE

Under this insurance policy, the insurance company will be relieved of payment of the special surgery benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Accident Related Legal Protection Cover

These special conditions set out the standard terms and conditions for the **accident-related legal protection cover of insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the insurance 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 and subject to the **General Terms and Conditions of 'TöbbMilliós Segítség' Accident Insurance (TMILL23)** (hereinafter: general conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other issues, the provisions of the **Hungarian Civil Code** and **other effective Hungarian regulations** shall apply mutatis mutandis to the contracts.

I. SUBJECT OF THE INSURANCE

Under the legal protection cover, the insurance company provides assistance to the insured in protecting his/her legal interests – in legal disputes which qualify as insured events; in particular

a) offers the insured legal advice in the event of a legal dispute,
b) offers legal representation to the insured in the legal protection matters specified in the policy conditions, whether in litigation or out-of-court settlement, and offers legal defense to the insured in misdemeanor or criminal proceedings, and
c) bear the costs of legal proceedings and legal representation necessary for the protection of the insured's legal interests, up to the sum insured.

II. INSURED EVENT

II.1. Insured event is an accident (including road traffic accidents) which the insured suffers and as a result:

- the insured dies, or suffers permanent health impairment, bone fracture(s), burns, or injuries which require surgical treatment or hospitalization (in patient treatment), and
- in relation to the accident, the insured's legal interests are harmed as a result of other persons' behavior or misconduct in the legal protection areas listed in Chapter 5, and the legal dispute may be settled out of court, through amicable negotiations.

II.2. **For the purposes of these conditions, the terms accident, accidental death, health impairment requiring surgery or hospitalization, permanent health impairment, bone fracture, and burn injury shall have the meanings assigned to them in the accident insurance section of these general and special conditions, mutatis mutandis.**

II.3. If claims made on the insurance policy arise out of events which were caused by the same incident, these events will be regarded as a single insured event, regardless of whether one or more insured parties were affected (related claims). Related claims shall also mean legal disputes concerning more than one insured parties arising out of the same accident. In respect of related claims, the sum insured may only be paid once for any one insured event, and the sum insured shall be the amount prevailing at the date of the first infringement or legal dispute which qualifies as an insured event.

III. DURATION OF THE INSURANCE COVERAGE (APPLICABILITY IN TIME)

III.1. **If the insured faces a legal dispute (has a legal claim he/she wished to assert) the insurance covers the insured incidents if the insured event (the conduct resulting in a legal dispute) occurred during the coverage period, and the insured's claim for legal expenses has been notified to the insurance company no later than within 30 days of the termination of the insurance policy.**

III.2. Subject to the provisions in this chapter, the insurance company shall continue to be liable for pending judicial or public proceedings until their binding resolution even if the insurance policy has terminated.

III.3. The insurance company does not stipulate a waiting period after the commencement of the insurance coverage.

IV. GEOGRAPHICAL LIMIT OF THE COVERAGE (GEOGRAPHICAL APPLICABILITY)

The insurance provides coverage for legal disputes which may be pursued within the territory of Hungary, or which may be referred to the jurisdiction of Hungarian courts or other Hungarian authorities.

X. LEGAL PROTECTION SERVICES

The insurance company offers legal protection services in the following areas (legal disputes):

V.1. Legal protection in personal injury claims related to the accident

a) This cover offers legal protection in personal injury claims opened to recover compensation from the party who was responsible for the insured's accident. The insurance also provides services to enforce claims for contractual and extracontractual damages under civil law, or against the employer in the event of a workplace accident, or against the insurance company providing the liability insurance, in the case of a road traffic accident.
b) The insurance provides services in the event of the insured's accidental death to enforce the claim for damages by the insured's relatives.

V.2. Legal protection in criminal and misdemeanor proceedings related to the accident

The insurance provides legal protection to the insured in criminal and misdemeanor proceedings if the insured is the injured party, a private litigant or substitute private litigant in the proceedings, or if the insured is the defendant or the person subject to such proceedings.

V.3. Legal protection in social and social insurance matters related to the accident

The insurance provides the following services:

a) counselling concerning social and public health insurance benefits in connection with the accident-related health impairment. The insurance company (or an attorney recommended by the insurance company) offers legal advice on one occasion per accident either orally (over the phone or in person), or in writing.

b) legal review of binding decisions or resolutions issued by social insurance administration bodies and other authorities exercising social administration functions in proceedings initiated in connection with accident-related health impairment

VI. EXCLUSIONS FROM THE INSURANCE COVERAGE

The insurance does not cover the defense of the legal interests:

a) in legal disputes between parties who are insured under the same insurance policy;

b) if the amount disputed or claimed (e.g.: damages, fine awarded in misdemeanor proceedings) is less than HUF 15.000;

c) to enforce claims which have been assigned to the insured, or to enforce claims for commitments which the insured assumed from a third party;

d) in claims which cannot be enforced through judicial channels;

e) in respect of claims arising out of this policy (both the accident insurance and legal protection covers) against the insurance company, as well as claims filed against the insurance company as an employer by the employer's own employees;

f) to enforce claims filed on pure emotional damage or psychiatric disorders suffered by the insured in relation to the accident, in connection with risks, losses and claims which arise out of or in relation to any activities or conduct which break the embargo implemented or imposed by the United Nations, the United Kingdom, the European Union, or the United States of America or infringe or violate any other economic, commercial or financial prohibition or restriction imposed by the same organizations or states.

VII. SUM INSURED

VII.1. **The insurance company will make a benefit payment based on the sum insured stated – in the certificate of coverage effective as of the date of the insured event or stated in the last indexation letter – for each occurrence and for the policy period in aggregate.**

VII.2. Sum insured per any one occurrence

The sum insured for any one occurrence is the maximum amount of a payout which may be made for any one insured incident, irrespective of the duration of bringing proceedings with respect to such insured event.

VII.3. Sum insured per any one policy period

VII.3.1. The sum insured specified for any one policy period shall be the total of payouts which may be made on all insured events within any one policy period.

VII.3.2. If the insured reports an insured incident which occurred in a policy period only in a subsequent policy period, the benefit payout of the insurance company with respect to the insured incident shall be based on the sum insured applicable to or remaining as of the date of the occurrence, and not based on the sum insured as of the date of the claim.

VIII. NOTIFYING A CLAIM FOR LEGAL PROTECTION, DUTY TO COOPERATE IN THE PROTECTION OF LEGAL INTERESTS

VIII.1. Notifying a claim for legal protection to the insurance company

VIII.1.1. The insured is required to notify the legal protection claim to the insurance company promptly but no later than within 15 workdays of being notified of the initiation of such proceedings. Claims may be reported:

- electronically (in an electronic mail sent to jogvedelem.hu@generali.com) or
- by fax, sending the claim to the fax number +36 1 301 7490,
- in person to the insurance intermediary or any customer service point of the insurance company,
- by phone, between 8am and 8pm on weekdays at the local toll number of Generali Customer Service Direct Line (+36 1 452 3333),
- on the Internet: using the online claim notification system (generali.hu/Online ugyfelszolgalat/Kárbejelentés),
- in a postal mail addressed to the Document Management Centre of Generali Biztosító Zrt., 7602 Pécs, PO Box 888.

VIII.1.2. When reporting a claim for legal protection, the insurance company must be provided detailed information on the following:

a) the date and place of the accident, its circumstances, the personal injury which the insured suffered in the accident as well as any related loss or damage, any authority proceedings related to the accident,

b) whether the insured intends to exercise the right to choose a attorney or trust the insurance company with selecting a legal representative.

VIII.1.3. **The insured shall make the following available to the insurance company:**

a) all documents available in connection with the accident (the accident/ road traffic accident/ workplace accident report, photographs, witness testimonies, insurance claim report, correspondence, vehicle registration certificate if the accident was a road traffic accident)

b) the documents of official investigations and proceedings initiated in connection with the accident

c) if the accident caused personal injury, the related medical documents (document of the first medical treatment, diagnosis of bone fracture, hospital discharge summary, etc.)

d) the assignment contract concluded with the insured's lawyer or the fee quotation submitted by the lawyer if the insured intends to exercise the right to choose a lawyer.

It is expedient to submit such documents to the insurance company already at the time of reporting the insured event.

VIII.1.3.1. In order to perform legal protection services, including indemnification for lawyer's fees and other legal expenses insured, the insurance company shall be entitled to request the insured to submit the following documents:

a) all contracts (e.g. employment, purchase, rental, lease, work, loan, etc. contracts) in connection with the gravamen;

b) photos and documents to evidence the legal grounds and the value of the legal dispute;

c) letters and other documents delivered to and received from the opponent party;
d) documentation of any legal/authority proceedings instituted in connection with such violation of a legally protected interest (petitions, minutes, court and authority resolutions);
e) in the event of an expert investigation in connection with such legal dispute, the expert opinion produced;
f) the fee quotation submitted by the lawyer to provide the insured legal representation, the contract of assignment concluded with such lawyer and the brief produced by such lawyer;
g) in the event that any invoice is required to be issued on legal expenses charged to the insured pursuant to any accounting regulations currently in effect (e.g. lawyer's fees), then such invoice, otherwise any voucher to evidence payment of legal expenses (e.g. duties, litigation costs payable to adverse party, etc.);
h) the insured's written declaration to exempt the lawyer providing the legal representation from their obligation of confidentiality;
i) in the event that the insured's medical data are required to be processed in order to perform the legal protection service, the insured's written statement of approval in respect of the processing of such medical data;
j) in the event that the legal protection service is in conjunction with a personal injury suffered by the insured / any social insurance benefits provided to the insured, then the insured's written declaration to exempt the physicians and healthcare institutions treating the insured / the social insurance administration organization from their obligation of confidentiality towards the insurance company.

In the event that the insured fails to perform the obligations set out in this section and therefore substantial circumstances regarding the assessment of the insured event and the insurance benefit may not be revealed, the insurance company shall not be obligated to provide a legal protection benefit and shall be entitled to reclaim any amounts already paid for the costs of legal proceedings.

VIII.2. Things to do before enforcing or averting claims and in the course of legal procedures

In the event that the insured applies for or is provided insurance protection, the insured is required to:
a) cooperate with the insurance company to reach an out-of-court settlement of claims;
b) request the insurance company's consent to any measure or procedural act (e.g. submitting a statement of claim or an appeal, requesting the court to delegate an expert, etc.) which affects or may affect the insurance company's obligation to provide benefits. The insurance company shall be entitled to deny payment for any expenses undertaken where the insurance company's approval was not previously requested.
c) request the insurance company's statement before the enforcement or aversion of claims before any court, challenging a court decision, and any major procedural acts – particularly as regards success perspectives – and to coordinate with the Insurance company in concluding compromises. Compromises failed to be agreed with the insurance company shall not be binding on the insurance company in respect of the insurance benefit.
d) keep the Insurance company informed on the status of claim enforcement (court / authority procedure) and to deliver any procedural documents (e.g. statement of claim, minutes of negotiations, petitions, court resolutions, etc.) to the insurance company within 5 days of reception thereof.

IX. CONDITIONS FOR CLAIMING SERVICES UNDER THE LEGAL PROTECTION COVER (ASSESSMENT OF PROSPECT OF SUCCESS, CONCILIATION PROCEDURE)

IX.1. Conditions for claiming covered services under the legal expenses cover

The insurance pays the legal expenses claim if all the following conditions are met:

- **the notified event is an insured event within the meaning set out in the policy conditions (Chapter II of these special conditions) and it is not excluded from coverage (Chapter VI of these special conditions) and**
- **the insurance coverage applies to the notified legal dispute (Chapters III, IV and V of these special conditions)**
- **the insured has already attempted to enforce the claim, but it was not productive and**
- **based upon the insurance company's assessment of the prospects of success, it is found that the claim may be reasonable pursued (Chapter IX of these special conditions).**

IX.2. Assessment of the prospects of success

IX.2.1. The insurance company is entitled to commence an investigation when a claim for benefits is notified and at any time during the procedure in respect of the prospective success of enforcing rights or of legal defense (assessment of the prospects of success).

IX.2.2. For the purposes of these special conditions, success of enforcing a claim (enforcing rights or legal defense) is presumable if:
- it can be rendered probable by applying the facts and the pertinent regulatory provisions that a court / authority resolution to award the insured shall be passed; and
- in case of enforcing a financial claim, it can be rendered probable that such claim will be paid.

IX.2.3. In the event that, upon examining the facts and based on the legal situation and the status of evidence, the insurance company comes to the conclusion that there is sufficient perspective of the success of enforcing the claim, the insurance company shall provide a written statement of fulfilling the claim for benefits and undertake to pay the costs insured.

IX.2.4. In the event that, upon examining the facts and based on the legal situation and the status of evidence, the Insurance company comes to the conclusion that there is no perspective of the success of enforcing the claim, the Insurance company shall be entitled to reject the fulfillment of legal protection services.

IX.2.5. The insurance company shall inform the insured in writing about the results of the assessment of the prospects of success within 15 days of the availability of all documents required for conducting such assessment, meaning whether the insurance company is to fulfill or deny the claim for benefits. Denial shall be justified by at least the fact rendering a reason for it or by calling attention to the legal or contractual provisions applicable thereto.

IX.2.6. When communicating the denial, the insurance company shall also advise the insured in writing of the possibility of a conciliation procedure and of the fact that if the conciliation procedure fails to be productive, the insured will be entitled to choose a legal representative in order to protect the insured's interests related to the insurance policy.

IX.2.7. In the event of a conflict of interests, the prospects of success will be assessed by the attorney appointed by the insured in accordance with the provisions in Chapter XI of these special conditions.

IX.2.8. The prospects of success are not assessed if criminal proceedings are brought against the insured.

IX.3. Conciliation procedure

IX.3.1. In the event that the insurance company refuses the delivery of legal protection services on the basis of its assessment of the prospects of success and the insured disagrees with the decision, the insured shall be entitled to initiate a conciliation procedure within 15 days of receiving the refusal.

IX.3.2. When initiating a conciliation procedure, the insured shall be required to name the attorney at law who represents him/her in the conciliation procedure and to submit the case assignment executed with the attorney. Within 5 days of the commencement of the conciliation procedure, the insurance company shall also be required to name its legal representative in the conciliation procedure.

IX.3.3. In the event that during the conciliation procedure, the legal representatives of the insured and of the insurance company

a) come to agree in respect of the prospect of success, both the insured and the insurance company shall be obligated to accept such decision.
b) fail to agree within 4 weeks in respect of the prospect of success, the insured shall be entitled to enforce the claim through a freely chosen legal representative (institute court proceedings) at the insured's own expense. In the event that the insured becomes a judgment creditor in the course of enforcing a claim, the insurance company shall be obligated to indemnify the insured for his/her legal expenses insured hereunder and not reimbursed in the lawsuit.

In the case of a court settlement, the insurance company shall bear the costs in the proportion of the judgment credit to the judgment debit.

The fees of the attorney representing the insured – including out-of-pocket expenses – shall be paid by the insurance company as provided in these policy conditions.

IX.3.4. The costs of the conciliation procedure shall be borne by the parties in the following proportions:

a) if the result of reconciliation is in favor of the insured, the costs of the procedure shall be borne by the insurance company;
b) if the conciliation procedure fails to be productive or its result is in favor of the insurance company, both the insured and the insurance company shall respectively bear their own costs.

IX.3.5. If the procedure of reconciliation fails, the insured will be entitled to freely choose a legal representative to protect his/her interests related to the insurance policy.

X. LEGAL REPRESENTATION OF THE INSURED

X.1. Subsequent to the occurrence of the insured event, and in any court or public administration proceedings or prior to the beginning of such proceedings, in the course of any procedure facilitating the avoidance of such proceedings, or if the conciliation procedure fails to be productive, the insured is entitled to freely choose his/her legal representative (attorney).

X.2. The right to choose a lawyer shall only apply to lawyers whose office is located at the insured's place of residence or at the seat of the court or public administrative authority which is competent in the procedure to be instituted at first instance. If there is no or only one attorney at such place of residence, another attorney within the area of competence of the county court can also be selected.

X.3. In the event that the insured does not exercise his/her right to choose an attorney, the insurance company shall recommend a attorney of adequate expertise or – by way of a separate power of attorney – the insurance company's legal counsel shall provide the insured with legal representation. X.4. The insured shall always be the party to establish an agency relationship with the attorney.

X.5. In the event that the insured exercises his/her right to choose a attorney, the insured shall be obligated to submit the signed case assignment concluded with such attorney – which includes the attorney's fee – within 2 workdays of contract conclusion. The insurance company shall only pay the lawyer's fee as specified in the contract of assignment if such fee has been previously approved by the insurance company.

X.6. The insured shall be obligated to exempt any lawyer providing him/her legal representation from their obligation of confidentiality and assign them to inform the insurance company on an on-going basis as regards the status of claim enforcement (court / authority procedure) and to make available any and all procedural documents (e.g. statement of claim, minutes of hearings, petitions, court resolutions) to the insurance company.

X.7. The attorney shall be directly responsible to the insured for fulfilling the assignment. The insurance company shall not be liable for the lawyer's operations.

XI. PROCEDURE TO BE FOLLOWED IN CASE OF A CONFLICT OF INTERESTS

XI.1. A conflict of interests shall in particular mean cases when, in relation to an insured event hereunder

a) the adverse party is provided with insurance protection by the insurance company pursuant to another insurance policy (e.g., third-party liability or legal protection insurance); or
b) the insurance company is the adverse party.

XI.2. In the event of a conflict of interests

a) the insured will be legally represented or provided legal advice by a freely selected lawyer in all cases;
b) the obligation to provide information on the legal dispute shall fall on the insured towards his/her attorney only. If, however, there is a conflict of interests because legal protection coverage is provided by the insurance company to the adverse party consequent upon the same insured event, the obligation to provide comprehensive information shall prevail towards the insurance company as well.
c) the prospects of success will not be assessed by the insurance company. The insurance company accepts the position of the attorney appointed by the insured party in respect of the prospect of success, provided that the attorney – in his/her written expert opinion – describes the reasons for a prospect of successfully exercising or defending the claim by giving a statement of facts as well as applicable legislative references.

XI.3. In the event of a conflict of interests, the insurance company will promptly inform the insured in writing of the existence of such conflict of interests and the provisions set out in Clause IX.2 of these special conditions.

XII. LEGAL PROTECTION SERVICES

XII.1. Legal Protection Services

In the event that a claim for services is eligible for fulfillment, the following legal protection services shall be provided by the insurance company depending on the type of gravamen:

XII.1.1. recommend a attorney of adequate expertise, unless the insured exercises his/her right to choose a attorney;

XII.1.2. provide verbal or written legal advice and/or cover the lawyer's fees of legal consultancy as set out in this clause;

XII.1.3. bear the costs of legal proceedings up to the sum insured as determined for each and every occurrence and in the aggregate for the policy period:

a) attorney's fees
This policy shall cover the reasonable and customary fees of a attorney undertaking the insured's legal representation in line with the actual assignment, including out-of-pocket expenses, subject to the insurance company's prior consent. In the event that the insured has agreed on the lawyer's fee without the insurance company's prior consent, the insurance company shall pay a fee corresponding to the minimum fee of an advocate as specified by law.

b) costs of legal proceedings
The insurance company shall indemnify for any and all fees and expenses of court, authority and mediation procedures (e.g. witness and expert fees, interpreter's fees, costs on on-site negotiation and inspection), provided that the insured is obligated to pay or advance such costs.

c) costs incurred by the adverse party
This policy shall cover the costs incurred by the adverse party in the event that the insured is required to pay them pursuant to the final ruling and there is no other insurance protection in effect.

d) enforcement costs
Enforcement costs shall be covered for up to 2 attempts of enforcement after the legal title of enforcement (e.g. judgment) is awarded to the insured.

e) costs of the expert opinion
This policy shall provide coverage for the costs of a written expert opinion by an independent expert hired by the insured, subject to the insurance company's prior consent to such expert assignment and the amount of such expert fee.

f) translation costs
This policy shall provide coverage for any reasonable translation costs of documents as required for conducting legal proceedings, subject to the insurance company's prior consent.

XII.2. Conditions for bearing legal expenses

XII.2.1. The policy shall only cover costs which are incurred after the insured event has been notified to the insurance company. Costs incurred before an insured event is notified shall only be covered under the policy if they are incurred as a result of measures taken by the counterparty, the competent authority or as a result of measures taken by the insured on grounds of urgency not earlier than 30 days before the insured event is notified.

XII.2.2. In the case of a court settlement, the insurance company shall bear the costs in the proportion of the judgment credit to the judgment debit. In the course of a lawsuit, the insured shall be obligated to submit a motion to the court to decide on bearing litigation costs. In the case of an out-of-court settlement, costs shall be borne by the insurance company unless the adverse party undertakes to reimburse them.

XII.2.3. In the event that – in case of a joinder of parties – the insured and the insured's co-plaintiffs or co-defendants are obliged by the court to collectively bear litigation costs, this policy shall cover litigation costs in the proportion that the insured's claim or the claim against the insured bears to the total value of the claim enforced by all co-plaintiffs or that of the claim against all co-defendants.

XII.2.4. In the case of bankruptcy or liquidation, this policy shall only cover the fees of the lawyer representing the insured, meaning that further procedural costs (e.g. duties, registration fees, publication costs) shall be excluded.

XII.2.5. In case of an arbitration procedure, legal expenses shall be covered up to the extent that the insured would be obligated in a standard court procedure to pay them.

XII.2.6. **The insurance does not cover**

a) **any fines imposed by reason of mala fide conduct of a lawsuit or negligence against the insured or his/her legal representative, and/or any additional costs consequent upon such conduct,**
b) **value added tax included in the legal expenses, provided that the insured is entitled to deduct it from the tax payable or to reclaim it.**

XII.2.7. **If claims which are only partially insured arise in the course of proceedings, the insurance company shall only pay those costs which would otherwise be payable by the insurance company without taking into consideration any claims not covered by insurance protection.**

XIII. INSURANCE COMPANY'S SUBROGATION (REIMBURSEMENT OF LEGAL EXPENSES TO THE INSURANCE COMPANY)

XIII.1. In the event that the insured enters into an out-of-court settlement with the adverse party and the adverse party undertakes to reimburse the insured's legal expenses (e.g. lawyer's fees), and if, in the course of legal proceedings, the court awards the insured any litigation costs and/or lawyer's fees, then any amounts collected therefrom may be claimed by the insurance company up to the amount paid out by the insurance company.

XIII.2. All legal expenses reimbursed in accordance with Clause XIII.1 must be refunded by the insured to the insurance company within 15 days of such repayment. In the event that the insured fails to take any measures to collect legal expenses awarded to the insured, the insurance company shall enforce a claim based on the agreement of assignment concluded with the insured. The insured shall be obliged to support the insurance company in enforcing any claims and to issue a deed of assignment in favor of the insurance company.

XIV. MISCELLANEOUS PROVISIONS

XIV.1. Insurance companies have the same obligation to keep any and all information, facts and data they obtain in relation to an insured event or the proceedings initiated in this context confidential as lawyers.

XIV.2. The insurance company hereby advises the policyholder that in order to avoid any conflict of interest between the insurance company and the insured, the insurance company has considered the options set forth in paragraphs a)-c) in Section 161 (1) of Act LXXXVIII of 2014 on the Insurance Business, and has adopted the solution described in paragraph a), which is: "its employees engaged in the management of legal expenses claims and the employees providing legal advice are not performing the same or similar services in any of the insurance company's other divisions or for any other insurance company in connection with any class of insurance defined in Part A) of Schedule No. 1 and that any executive manager of the insurance company installed as a superior officer for these employees shall not be installed in a similar position in connection with the management of claims in other branches of insurance".

Special Conditions of the Patient Transport and TeleDoctor Service Cover

These conditions of assistance services set out the standard terms and conditions of the **assistance services offered under the TöbbMilliós Segítség Accident Insurance of Generali Biztosító Zrt.** (hereinafter: insurance company), provided that the insurance policy has been concluded by reference to these policy conditions.

The assistance services are offered by the insurance company through a service provider partner appointed to provide specific assistance services (hereinafter: Assistance Partner) If the cooperation with the Assistance Partner is terminated, the insurance company will take all reasonable measures to cooperate with another assistance partner in Hungary and continue to provide services of similar quality. The insurance company shall inform the policyholder of any change in the Assistance Partner.

The insurance company is entitled to unilaterally terminate the provision of the assistance service. The insurance company shall inform the policyholder of the termination of the service 60 days before the termination takes effect.

I. TERMS AND DEFINITIONS

Assistance Partner: Europ Assistance Magyarország Kft. (registered seat: **1132 Budapest, Váci út 36–38.**), the company appointed by Generali Biztosító to provide assistance services.

Telephone number dedicated by the Assistance Partner: the Assistance Partner operates a 24-hour live customer service line at +36 1 465 3683 to provide customers with medical information and arrange health care services for them

Inpatient care: health care treatment provided to a patient in a medical facility offering hospitalization (within the meaning of Clause IX.3 of the general conditions). The service may be provided pursuant to the referral of the physician providing regular care to the patient, the treating physician or by any other person with authority, after the patient has applied for the service.

II. DEFINITION OF THE COVERED SERVICE

Depending on the insurance plan selected at the time when the insurance policy is concluded, the insurance company shall arrange and pay for the following services to be provided to the insured by the Assistance Partner from the commencement of the coverage:

– TeleDoctor Service through the entire term of the insurance coverage,
– Patient transportation service following inpatient hospital care resulting from an accident occurring during the insurance coverage period.

II.1. TeleDoctor service

During the term of the insurance coverage, the Insured covered under **TöbbMilliós Segítség Accident Insurance** may use the Teledoctor Service on unlimited occasions by calling the phone number dedicated to this service by the Assistance Partner.

The TeleDoctor Service is available to the insured 24 hours a day. If the insured's call cannot be taken by a qualified medical professional, the operator of the Assistance Partner will schedule a convenient date and time for returning the insured's call.

The TeleDoctor Service does not offer medical diagnosis and by no means intends to replace the direct contact between the physician and the patient, emergency medical assistance, or GP and specialized physician appointments.

During the telephone call, the operator does not take the caller's medical history, and is not allowed to recommend treatment for specific symptoms or complaints which would require a physical exam.

The TeleDoctor Service does not include administrative assistance with ordering the following services and does not cover the costs of such services. Under the TeleDoctor Service, the Assistance Partner will offer information about the following topics:

- 24-hour information telephone line:
  – doctor's offices, pediatrician's offices, out-of-hours medical services,
  – specialty care clinics and out-of-hours medical services,
  – pharmacies and out-of-hours pharmacies.
- Medical Assistance
  In office hours (from 8am to 4pm) immediate assistance; outside office hours, your call is returned on the next workday.
  General medical opinion, guidance in accordance with the following:
  – general medical guidance,
  – general information about diagnostic test results, diagnosis, medication,
  – recommendation of specialty care clinics.

In order to receive the TeleDoctor Service, the insured shall provide the following information to the Assistance Partner:

– insured's name;
– insured's date and place of birth,
– insured's mother's name.

II.2. Patient transport

Insured event: the transportation of the insured from the hospital following the insured's hospitalization related to an accident which occurred during the coverage period of the insurance policy.

Date of the insured event: the date of when the insured is transported from the hospital.

Geographical limit: Hungary The service is available from medical service providers in Hungary.

The insurance company provides the following services during the coverage period through its Assistance Partner:

The insurance company will arrange and pay for the insured's transportation – not requiring qualified medical personnel (e.g.: ambulance technician, physician, paramedic) to be present – following the insured's hospitalization related to the insured event in a patient transport vehicle from the hospital to a Hungarian address specified by the insured. The insurance company will not consider the mobility of the insured at the time when this service is claimed.

The Assistance Partner will pay for the costs of the patient transport directly to the patient transport service provider. The insured shall not bear any costs in relation to the patient transportation service.

Limitation of the service: this service is offered through the Assistance Partner only once in any one policy year during the insurance coverage in relation to one insured event.

Notifying a claim for the patient transport service and conditions of service provision

To claim the patient transport service, the insured shall contact the Assistance Partner by calling the dedicated customer service line.

A patient transport claim may be notified 24 hours a day, with the limitation that the Assistance Partner only guarantees patient transport to be arranged for the next day, if the claim is notified by 14pm on the previous day.

When a service claim is notified, the Assistance Partner will check is the insured is covered. If the insured is covered and eligible to claim this service, the Assistance Partner will promptly begin to arrange the service.

In order to receive the Patient Transfer service, the insured shall provide the following information to the Assistance Partner:

- insured's name;
- insured's date and place of birth,
- insured's mother's name;
- name and address of the medical facility providing in-patient care,
- destination address.

Patient transport does not mean immediate availability. The insured is required to notify a claim for patient transport no later than by 14pm on the day preceding the day when the patient transport service is requested to be provided by calling the dedicated customer service line operated by the Assistance Partner. In that case, the Assistance Partner undertakes to arrange patient transport for the next day at the earliest, or for the day specified by the insured. The Assistance Partner will notify the insured within 4 hours following the notification of the claim about the estimated time of the patient transport.

If the insured notifies a claim for patient transport later than 14pm on the day preceding the day when the patient transport service is requested to be provided, the Assistance Partner will try to arrange patient transport for the next day, but failing to provide the service shall not mean a breach of the terms of the assistance services.

Patient transport is only covered under this insurance if it is claimed from and arranged by the Assistance Partner.

The Assistance Partner may have the above facts verified and get a second opinion on the insured's conditions by contacting the treating hospital or from the treating medical personnel by telephone, e-mail or facsimile (at its own discretion). The Assistance Partner may have the above facts verified and get a second opinion on the insured's conditions by contacting the treating hospital or from the treating medical personnel by telephone, e-mail or facsimile (at its own discretion). The Assistance Partner is entitled to deny service of the treating hospital does not cooperate, and thus the information required for arranging patient transport may not be obtained.

The insured is required to present the medical discharge documents to the patient transport personnel. Failing that, the patient transport provider or the Assistant Partner may deny service provision.

If patient transport becomes impossible for any reason, the insured is required to cancel the service claim promptly, but no later than within 4 hours before the estimated time of the patient transport ordered, by calling the dedicated customer service line operated by the Assistance Partner (the insured's prompt disclosure duty). Failing that, the insured will no longer be eligible to the patient transport service.

Neither the Assistance Partner, nor the patient transport service provider is required to verify whether the insured is in a condition fit for transport; in this respect, it will only rely on the documents issued by the hospital.

III. TERMINATION OF ASSISTANCE SERVICES

The insurance company is entitled to unilaterally terminate the provision of the assistance service. The insurance company will inform the policyholder of its intention to terminate the assistance service within 60 days before the termination takes effect, and the assistance service will be terminated in respect of all insured persons.

In the event of termination of the assistance service, the policyholder is entitled to terminate the insurance policy in writing, without observing a notice period.

IV. EXCLUSIONS

Regarding assistance services, the insurance company shall be relieved from providing patient transport and TeleDoctor services in the cases described in Chapter VI of the general conditions, and the policy does not cover the cases listed in Chapter VII of the general conditions.