Special Conditions of

TESTŐR

Term Life, Accident and Health Insurance

Effective from: July 7, 2022

Nysz.: 23176

Contents

Special Conditions of Term Life Insurance (EEHAT022)

These special conditions set out the standard terms and conditions for the **term life cover** of insurance policies (death benefit) 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 the General Terms and Conditions of TestŐr Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

For the purposes of an insurance contract concluded pursuant to these special conditions (hereinafter: contract), insured events shall be:

I.1. **The insured's death while the insurance policy is in force.**

The date of the insured event is the date of the death.

I.2. A diagnosis of a critical illness during the coverage period.

Critical illnesses include:

I.2.1. The stage of **myocardial infarction** (heart attack) where the transmural necrosis of the affected heart muscle segment is also accompanied with cardiomyopathy, and the follow-up echocardiography run at least two months after the myocardial infarction shows characteristic images of cardiomyopathy and myocardial infarction with the ejection fraction (EF) estimated to be lower than 30%.

Date of the insured event (diagnosis): the date of a diagnostic report of the follow-up medical examination confirming the insured event through medical test findings.

I.2.2. A **malignant tumor** of such severity where the insured's surgery, chemotherapy or radiation therapy was unsuccessful and after completing active treatment there is still apparent evidence of a tumor, or where the insured was diagnosed with terminal cancer and was recommended only palliative care.

Date of insured event (diagnosis): date of the follow-up examination after the end of treatment, or, in the case of untreated cases, the date of the medical document justifying the insured event following the examination.

I.2.3. **Cerebrovascular accident** is a form of brain damage caused by acute circulatory failure of a vessel within the cranial cavity of the brain, of such severity that, after 30 days following its onset, the insured person can only be fed by an artificially created feeding gastrostoma or jejunostomy, provided that the stoma is created within the policy period.

Date of the insured event (diagnosis): the date of occurrence of an acute cerebrovascular insult which results in an insured event.

II. INSURANCE BENEFIT

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

II.1. Death benefit

If the insured dies during the coverage period, the sum insured **set out in the certificate of coverage effective as of the date of the death – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter** will be paid to the beneficiary entitled to the death benefit in respect **of this cover** and at the same time the insurance policy will terminate.

II.2. Premature Payout

If the insured is **diagnosed with a critical illness (which meets the definition in Clause I.2)** during the coverage period, the insurance pays out **100% of 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 offer letter** as a premature benefit payout, and at the same time the insurance policy will terminate.

III. INSURANCE PREMIUM

III.1. Before the approval of the insurance application, **the insurance company may require the insured to answer questions about his/her smoking habits** in addition to the standard requirements set forth in the general conditions.

III.2. Based on the answers of the insured, **the insurance company will classify the insured** into the Basic Category, the Preferential Category or the Optimum category according to his/her smoking habits (hereinafter: **category according to smoking habits**), which will also be indicated on the insurance application.

III.3. The insured is classified into the **Optimum Category** if he/she is a non-smoker at the time of concluding the insurance policy and have not smoked at all in the preceding two years, and such fact may be confirmed by a smoking test, ordered by chance.

III.4. To qualify for the **Preferential Category,** the insured person must have stopped smoking within two years, or smoke no more than 6 cigarettes a day, as confirmed by any smoking test ordered by chance.

III.5. An insured person shall be classified in the **Basic Category** if he or she consumes 7 or more cigarettes or equivalent tobacco products per day, or smokes a pipe or cigars.

III.6. Before the approval of the insurance application, **the insurance company is entitled to carry out a smoking test** for the insured's **nicotine use,** and **to adjust the original smoking habits category indicated in the insurance application based on the results of the test examination. The insurance company must indicate the modified category on the certificate of coverage in a visually distinctive manner.**

III.7. In addition to the provisions set forth in Clause IV.1.2. of the general conditions, the **insurance premium shall be determined** based on the **insured's category according to smoking habits.**

IV. THE INSURED'S DUTY TO NOTIFY CHANGES

If an insured is classified into the Optimum Category, in addition to the obligations specified in Clause III.2. of the general conditions, such insured shall be obliged to notify to the insurance company any change in his/her smoking habits, i.e. if he/she has started smoking, within 5 workdays in writing. For the purposes of this life insurance smoking habits shall be relevant material circumstances. If the insured fails to comply with this obligation to communicate a change, the insurance company may be relieved from the benefit payment in accordance with Clause VI.1. of the general conditions.

V. THE INSURER'S OPTION TO AMEND THE POLICY

V.1. In the case defined in Chapter IV of these special conditions, the insurance company will classify the insured into either the Preferential Category or the Basic Category **with effect from the next insurance anniversary after the notification of change is delivered** and subject to the provisions of Chapter III of these special conditions.

V.2. In the case set forth in Chapter IV of these special conditions, the **insurance premium will be modified with effect from the next insurance anniversary after the notification of change is delivered.** The **modified insurance premium shall be determined** pursuant to the premium rates table of the insurance company effective at the time when the insurance policy is taken out, **based on the insured's current age, activities** (occupation, work, sport), **smoking habits** and the **sum insured** as well as the **remaining duration of the insurance policy.**

V.3. In the case set forth in Chapter IV of these special conditions, the **policyholder is entitled to request** that the **insurance premium** effective as at the date of the notification **will not be modified with the sum insured reduced with effect from the next renewal date after the notification of the change has been sent.** The **reduced sum insured shall be determined** pursuant to the insurance company's Premium Rates Regulations **effective at the time when the insurance is taken out,** based on the **insured's current age, activities** (occupation, work, sport), **smoking habits** as well as the policy's **insurance premium** effective at the time when the change is notified and the **remaining duration** of the insurance.

VI. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

VI.1. The insurance claim must be notified to the insurance company **within 15 days** (or 45 days in the case of a cerebrovascular accident) of the death or of the occurrence of the insured event.

VI.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

VI.3.1. a **duly completed standard insurance claim form** made available by the insurance company,

VI.3.2. **in the case of a death benefit claim, a copy of the following documents – in addition to the documents listed in Clause VI.3.1 – must also be attached to the insurance claim:**

a) cause of death medical certificate /hospital course summary,
b) autopsy report,
c) the insured's certificate of death,
d) if the insured **dies as the result of an illness,** the documents necessary to clarify the date of onset and course of the illness that caused the death of the insured person and the more specific circumstances of the death (treating physician's statement, hospital discharge summary, etc.)
e) if the insured **dies as the result of an accident:**
   – all medical documents produced in connection with the insured event from the date of the accident until notifying the insurance claim, in particular the medical documentation of the first medical care,
   – the accident & injury report/ the workplace A&I report / the police report, if one was made,
   – the result of the blood alcohol test and/or drug test, if one was administered,
f) **in the case of a road traffic accident,** in addition to the above:
   – if the insured was injured in a road accident as a driver of a vehicle, a copy of the driver's license and the vehicle registration certificate.
g) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

VI.3.3. **When an early partial payout is claimed,** a copy of the following documents, **in addition to the documents listed in Clause VI.3.1** shall also be submitted:

a) **In the case of myocardial infarction (Clause I.2.1.)**
   – medical documents confirmatory of the diagnosis of myocardial infarction (heart attack) and
   – cardiac ultrasound scan and related cardiological test results during a follow-up examination.
b) **In the case of malignant tumors (Clause I.2.2.)**
   – positive histopathology and other test findings (describing the malignant nature of cells and their invasive or metastatic spread) and
   – documents of the follow-up examination after the active treatment(s) (surgery, radiotherapy, chemotherapy) has/have been completed or medical documents of the investigation of the disease.

c) **In the case of a cerebrovascular accident (Clause I.2.3.)**
   – the hospital discharge summary,
   – the medical document describing the stoma surgery,
   – all medical documentation produced from the occurrence of the acute cerebrovascular accident until the stoma is created, or until the follow-up visit 30 days after the circulatory accident occurred.

VI.4. The insurance company shall be entitled to pay the benefit subject to the submission of the following documents:
   – an official certificate of the insured person's date of birth.

VII. INSURANCE COMPANY'S EXEMPTION FROM THE DEATH BENEFIT, AND EXCLUSIONS

In the case of this insurance policy, the insurance company will be relieved from the payment of the death 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.

Information on the Total Cost Indicator (TCI)

applicable to the Special Conditions of TestŐr Term Life, Accident and Health Insurance

Effective from: July 7, 2022 until repealed

DEAR VALUED PROSPECTIVE CUSTOMER,

The insurance you intend to take out is a traditional life insurance policy with a savings component.

To provide customers with an overall view of what costs are charged on insurance products, insurance companies apply a standard formula to calculate the total cost indicator (TCI) in respect of the insurance products listed in Act LXXXVIII of 2014 on the Insurance Business (hereinafter: Insurance Act). The Total Cost Indicator is communicated to all prospective customers so that they can make an informed decision about purchasing insurance. The TCI is calculated according to the standard formula set out in Decree 55/2015 of the National Bank of Hungary (hereinafter: Decree) on the Calculation and Disclosure of the Total Cost Indicator.

What is TCI?

The Total Cost Indicator (or TCI) is a simple indicator designed to inform You of the fees and charges associated with the insurance product, expressed as a percentage (as explained in the example below). The TCI typically includes the price of the covered risks incorporated into the product.

Practically, the TCI shows the approximate yield loss You may incur under certain assumptions in comparison to the yield on a theoretical cost-free investment, attributable to the fact that that yield was earned on a traditional life insurance product.

How does the TCI help you?

TCI helps you to easily compare the costs of traditional life insurance products offered in the Hungarian insurance market.

TCI explained through the following an example:

The TCI is calculated using the following assumptions defined in the Decree.

The age of the insured and the policy term

– The insured is a 35-year-old person, who
  - takes out insurance with regular premium payment for a period of 10, 15 or 20 years,
  - takes out insurance with single premium payment for a period of 5, 10 or 20 years.

The TCI is calculated for different policy periods so that you can see how the policy term impacts the proportion of the cost of the product. If the TCI is not calculated for any of the above policy terms, it means that the specified product may not be taken out for that specific duration.

For whole-life insurance, the policy periods shall be understood as periods at the end of which the customer surrenders the insurance.

The insurance premium and the method of premium payment

– An insured of the above age takes out the insurance
  - with a single premium of HUF 4 500 000, or
  - with a regular monthly premium of HUF 25 000, where the premium is paid by bank transfer.

Term life and/or accident or health insurance covers included in the traditional life insurance

– The TCI is calculated with the risk premium of the minimum insurance coverage required to be selected in accordance with the policy conditions.

– Under TestŐr Term Life, Accident and Health Insurance, the minimum required cover to be included in the insurance: term life insurance cover.

Pursuant to the Decree, the insurance company is required to include in the TCI calculation all costs associated with the product which reduce the value of the investment and which are incurred because you have chosen to invest in a traditional life insurance product. However, taxes and social contributions payable or tax credits or allowances granted on insurance premiums and claims paid will be ignored.

TCI for this TestŐr Term Life, Accident and Health Insurance:
for 10 years: 43.05%
for 15 years: 32.53%
for 20 years: 26.57%

Please note that although the TCI is also calculated for this product, this type of insurance is primarily intended to cover life insurance risks and not for accumulating savings.

Please note!

It is important to note that in the above examples TCI has been calculated based on the assumption – besides the core parameters – that the policy is kept in force, its terms are not modified, it is not cashed out in any form, and all premiums are paid in full and as due throughout the entire policy duration. Therefore, the cost level illustrated by the calculated TCI is not necessarily identical to that of the actual insurance policy you intend to purchase; it is for information purposes only. **Based on the unique features of an insurance policy, actual costs may substantially differ from the disclosed TCI.**

The website of the Magyar Nemzeti Bank (Hungarian National Bank) contains all TCI values subject to the TCI calculation obligation under the Decree.

Please also note that while TCI is a key indicator, it is not the only essential point in our customer information about traditional life insurance products. You may also wish to consider what insurance coverage (life, accident, or health insurance) is offered in the particular quote with what limits. Since this type of investment is for the long term, you may also need to consider how flexibly you can modify the insurance policy if your circumstances change during the policy period (e.g.: to add new covers), or how easily you can cash in the funds paid on the policy, or what additional convenience services are offered by the insurer to best meet customer demands.

Thank you for reading this information. We do trust that by introducing the Total Cost Indicator we have made the comparison of the costs of the various life insurance products easier and more transparent, and ultimately, we have provided you with all the information you need for making an informed decision before purchasing insurance.

Generali Biztosító Zrt.

This Annex is part of the Special Conditions of TestŐr Term Life, Accident and Health Insurance.

Special Conditions of Accidental Death Insurance (EBHAT022)

These special 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) which **occurs during the coverage period and the insured dies within one year** as the result of such accident.

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

II. INSURANCE BENEFIT

If an **insured event specified in the insurance policy occurs,** the sum insured **set out in respect of this risk in the certificate of coverage or indexation offer letter** in force at the time of death – **the last one in force following the termination of the insurance policy – will be paid to the beneficiary entitled to the death benefit,** and at the same time the insurance policy will terminate.

If the **insured dies after the termination of this insurance policy as the 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 based on the **sum insured specified in respect of this risk on the last certificate of coverage in force or in the last indexation offer 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) cause of death medical certificate / hospital course summary,
b) the autopsy report, if one was made;
c) the death certificate of the insured;
d) 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;
e) the accident & injury / workplace A&I / police report, if one was made,
f) the result of the blood alcohol and/or drug test, if one was administered,
g) in the case of a road accident, in addition to the above
   – if the insured **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.
h) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

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

In the case of this insurance policy, the insurance company will be relieved of payment of the accidental death 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 Accidental Permanent Disability Insurance with Linear Benefit Payment (EBROK022)

These special conditions set out the standard terms and conditions for the **accidental permanent disability cover with linear benefit payment** 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (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 disability.**

I.2. **For the purposes of this insurance, disability** means a **physical and/or mental impairment which limits the ability to carry out a normal way of life.**

I.3. **Disability is permanent** if the **medical condition** of the insured is **unchanging or stable.** If the degree of the disability is **still constantly changing,** but 2 years have passed since the date of the accident, then **after 2 years from the date of the accident, the medical expert of the insurance company will determine the degree of the disability, which the insurance company** will **consider as permanent disability** as the result of the accident for the purposes of determining the amount of the benefit. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. **No adverse aesthetic effect or other (social, financial, etc.) detriment** caused by the accident **shall in itself be grounds for an insurance claim for permanent disability (health impairment).**

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

II. INSURANCE BENEFIT

II.1. **The insurance company will only pay the insurance benefit if the disability is confirmed to be permanent** (within the meaning of Clause I.3.).

II.2. **If an insured event occurs, the insurance company shall pay a percentage of the sum insured stated in respect of this covered risk in the certificate of coverage effective as of the date of when the extent of the permanent disability was established – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter, corresponding to the extent of the permanent disability,** subject to Clause II.9 of these special conditions.

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

II.4. If the extent of the disability **cannot be established based on 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 the disability determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (health impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the disability by the insurance company's physician-expert, or for determining the amount of the benefit payable by the insurance company. **Furthermore, no expert opinion or resolution of any other medical expert board may be used as a reference binding the insurance company in determining the permanent nature of the impairment or the extent thereof.**

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

II.6. **If the insured dies before his/her disability (health impairment) could become permanent, the benefit shall be determined based on the extent of the disability confirmed by the insurance company's physician based on the documents of the last medical examination.**

II.7. **No claim on permanent disability** may be made **if the insured dies within 15 days after the accident.**

II.8. **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.9. **If the insurance company has already made a benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file a supplementary insurance claim, supported by all the necessary medical documents in proof of the deterioration of the insured's condition** despite appropriate medical treatment, once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim, and may request that his/her condition be reassessed and the extent of the permanent disablement be determined again. Based on the findings of the medical review, the insurance company shall pay the insurance benefit in accordance with Clause II.2 of these Special Conditions, on the understanding that any **benefit payouts made earlier on the insured event referred to above shall be deducted from any later benefit payout.**

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy 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, or the workplace accident & injury report if one was made,
c) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.
e) other documents required to clarify the circumstances of the accident.

III.4. **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 based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.6. 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 disability 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 disability is confirmed to be permanent,** or **within 15 days after the expiry of 4 years following the accident.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the permanent disability linear 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 Accidental Permanent Disability Insurance with Progressive Benefit Payment (EBROK122)

These special conditions set out the standard terms and conditions for the **accidental permanent disability cover with progressive benefit payment** 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

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

I.2. **For the purposes of this insurance, disability** means a **physical and/or mental impairment which limits the ability to carry out a normal way of life.**

I.3. **Disability is permanent** if the **medical condition** of the insured is **unchanging or stable.** If **the degree of the disability is still constantly changing,** but 2 years have passed since the date of the accident, then **after 2 years from the date of the accident, the medical expert of the insurance company will determine the degree of the disability, which the insurance company will consider as permanent disability** as the result of the accident for the purposes of determining the amount of the benefit. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. **No adverse aesthetic effect or other (social, financial, etc.) detriment** caused by the accident **shall in itself be grounds for an insurance claim for permanent disability (health impairment).**

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

II. INSURANCE BENEFIT

II.1. **The insurance company will only pay the insurance benefit if the disability is confirmed to be permanent** (within the meaning of Clause I.3.).

II.2. **If an insured event occurs, the insurance company shall pay a percentage of the sum insured stated in respect of this covered risk in the certificate of coverage effective as of the date of when the extent of the permanent disability was established – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter, applicable to the extent of the permanent disability specified in this Clause,** subject to Clause II.9 of these special conditions.

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

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

extent of disability → benefit %
26% → 27%
27% → 29%
28% → 31%
29% → 33%
30% → 35%
31% → 37%
32% → 39%
33% → 41%
34% → 43%
35% → 45%
36% → 47%
37% → 49%
38% → 51%
39% → 53%
40% → 55%
41% → 57%
42% → 59%
43% → 61%

extent of disability → benefit %
44% → 63%
45% → 65%
46% → 67%
47% → 69%
48% → 71%
49% → 73%
50% → 75%
51% → 78%
52% → 81%
53% → 84%
54% → 87%
55% → 90%
56% → 93%
57% → 96%
58% → 99%
59% → 102%
60% → 105%
61% → 108%
62% → 111%

extent of disability → benefit %
63% → 114%
64% → 117%
65% → 120%
66% → 123%
67% → 126%
68% → 129%
69% → 132%
70% → 135%
71% → 138%
72% → 141%
73% → 144%
74% → 147%
75% → 150%
76% → 153%
77% → 156%
78% → 159%
79% → 162%
80% → 165%
81% → 168%

extent of disability → benefit %
82% → 171%
83% → 174%
84% → 177%
85% → 180%
86% → 183%
87% → 186%
88% → 189%
89% → 192%
90% → 195%
91% → 198%
92% → 201%
93% → 204%
94% → 207%
95% → 210%
96% → 213%
97% → 216%
98% → 219%
99% → 222%
100% → 225%

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

II.4. If the extent of the disability **cannot be established based on the table,** it 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 the disability determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (health impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the disability by the insurance company's physician-expert, or for determining the amount of the benefit payable by the insurance company. **Furthermore, no expert opinion or resolution of any other medical expert board may be used as a reference binding the insurance company in determining the permanent nature of the disability or the extent thereof.**

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

II.6. **If the insured dies before his/her disability (health impairment) could become permanent, the benefit shall be determined based on the extent of the disability confirmed by the insurance company's physician based on the documents of the last medical examination.**

II.7. **No claim on permanent disability** may be made **if the insured dies within 15 days after the accident.**

II.8. **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.9. **If the insurance company has already made a benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file a supplementary insurance claim, supported by all the necessary medical documents in proof of the deterioration of the insured's condition** despite appropriate medical treatment, once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim, and **may request that his/her condition be reassessed and the extent of the permanent disability be determined again.** Based on the findings of the medical review, the insurance company shall pay the insurance benefit in accordance with Clause II.2 of these special conditions, on the understanding that **benefit payouts made earlier on the insured event specified above shall be deducted from any later benefit payout.**

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy 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, or the workplace accident & injury report, if one was made;
c) the blood alcohol and/or intoxicant test results, if one was administered;
d) in the case of a road traffic accident, in addition to the above:
   – a copy of the police report, if one was taken,
   – if the insured **was injured in a road traffic accident** as the **driver of a motor vehicle,** his/her driving license and the vehicle registration certificate.
e) other documents required to clarify the circumstances of the accident.

III.4. **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 based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.6. 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 disability 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 disability is confirmed to be permanent,** or **within 15 days after the expiry of 4 years following the accident.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the accidental permanent disability with progressive payout 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 Accidental Permanent Partial Disability to an extent exceeding 50% Insurance (EBROK222)

These special conditions set out the standard terms and conditions for the **accidental permanent disability to an extent exceeding 50% cover** of insurance policies offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of Test-Őr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) which occurs while the insurance policy is in force and **as the result of which the insured suffers permanent disability to an extent exceeding 50%.**

I.2. **For the purposes of this insurance, disability** means a **physical and/or mental impairment which limits the ability to carry out a normal way of life.**

I.3. **Disability is permanent** if the **medical condition** of the insured is **unchanging or stable.** If the degree of the disability is **still constantly changing,** but 2 years have passed since the date of the accident, then **after 2 years from the date of the accident, the medical expert of the insurance company will determine the degree of the disability, which the insurance company** will **consider as permanent disability** as the result of the accident for the purposes of determining the ground for the claim. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. **No adverse aesthetic effect or other (social, financial, etc.) detriment** caused by the accident **shall in itself be grounds for an insurance claim for permanent disability (health impairment).**

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

II. INSURANCE BENEFIT

II.1. The insurance company **will only pay the insurance benefit if the disability** (within the meaning of Clause I.3.) **is permanent and its extent exceeds 50%.**

II.2. If the **degree of the insured's disability is continuously changing, both the insured and the insurance company are entitled to request a medical review** of the permanent impairment or the extent of such permanent disability **once a year with respect to each insured event, for a period of 4 (four) years after the reported accident.** Thus, both the insured and the insurance company are entitled to request a medical review to determine whether the insured's health is medically unchanging, stable. The insured may request that his/her condition be reviewed and the permanent nature as well as the extent of the impairment be determined by **submitting a supplementary insurance claim** and the **medical documents in proof of a deterioration of his/her condition** despite appropriate medical treatment.

II.3. **If an insured event occurs, the insurance company will pay the sum insured stated in respect of this covered risk in the certificate of coverage effective as of the date of when the permanent disability of an extent exceeding 50% was established – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter, and the part of the insurance policy relating to accidental permanent disability of an extent exceeding 50% will be terminated.**

II.4. **The extent (degree) of any permanent disability on which the insurance claim is based, shall be confirmed by the insurance company's medical examiner pursuant to the table in Schedule B which shall form an integral part of the general conditions.**

II.5. If the extent of the disability **cannot be established based on 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 degree of disability established in the opinion of the **National Institute of Medical Experts** (the body authorized to determine the degree of disability (health impairment) as defined in the Hungarian legislation in force at the time) or in **the decision of the pension insurance administration body** shall **not be taken as a basis for** determining the extent of disability to be established by the insurance company's medical expert. **Furthermore, no expert opinion or resolution of any other medical expert board may be used as a reference binding the insurance company in determining the permanent nature of the disability or the extent thereof.**

II.6. **If the insured person dies before the disability becomes permanent** and the insurance company's medical expert has determined, on the **basis of the last medical examination,** that **the degree of the disability to be taken into account exceeds 50%, the insurance company will pay the sum insured stated in respect of this covered risk in the effective certificate of coverage – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter.**

II.7. **No claim on permanent disability** may be made **if the insured dies within 15 days after the accident.**

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy 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, or the workplace accident & injury report if one was made,
c) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.
e) other documents required to clarify the circumstances of the accident.

III.4. **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 based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.6. **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 disability 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 disability is confirmed to be permanent,** or **within 15 days after the expiry of 4 years following the accident.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the >50% accidental permanent disability 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 Bone Fracture Insurance (EBCST022)

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

In the case of matters not regulated by these special conditions, the insurance shall be governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the Hungarian Civil Code and other effective Hungarian legal acts shall apply mutatis mutandis to the policy.

I. INSURED EVENT

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

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

II. INSURANCE BENEFIT

If an insured event defined in the insurance policy occurs, the insurance company **will pay the sum insured per accident, irrespective of the number of fractures, stated in respect of this risk 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 offer 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) the radiology (x-ray) report or medical certificate confirming the fracture,
b) all medical documents related to the insured event from its occurrence until the notification of the insurance claim,
c) the accident & injury report, or the workplace A&I report if one was made,
d) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **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 based on the findings of such review.**

III.5. The insurance company may stipulate that a medical examination is required for the payment of the claim – in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.

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

In 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 Insurance (EBLRS022)

These special 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

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

a) **joint dislocation:** occurs when the bones in the shoulder, elbow, wrist, hip, knee, or ankle joints are displaced or dislocated from normal position, and they cannot be spontaneously reduced or manipulated back into position before the diagnostic imaging test confirms the dislocation.
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 ultrasound or MR scan, or medical documentation and an operative report, where the injured joint is operated on (ligament suture or ligament replacement) or fixed (plaster or rigid plastic fixation) for at least four weeks within one week of the date of the accident.

c) **muscle tear:** an injury of a muscle or tendon to an extent which 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 BENEFITS AND LIMITATIONS TO BENEFIT PAYMENT

II.1. If an insured event defined in the insurance policy occurs, the insurance company **will pay the sum insured – per accident, irrespective of the number of incidents specified in Clause I.1 – stated in respect of this risk 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 offer letter.**

II.2. **If a particular joint is injured multiple times, the insurance only pays 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy of the following documents:**
- 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 result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.
- other documents required to clarify the circumstances of the accident.

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

a) 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.

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

c) 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. **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.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

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

In 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 Accidental Hospitalization Insurance with Daily Allowance (EBKNT022)

These special conditions set out the standard terms and conditions for the **accidental hospitalization daily payment 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **an accident** (within the meaning of Clause IX.1. of the general conditions) **which occurs during the coverage period,** as the result of which the **insured receives continuous inpatient hospital care** (within the meaning of Clause IX.4. of the general conditions) provided that such hospital care is medically required.

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 day if his/her discharge from the hospital is on a later day than that of his/her admission. With respect to in-patient care, for the purposes of determining the insurance benefit payout (Chapter II of these policy 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 BENEFIT

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 these 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 **amount of the benefit payable** for the insured's inpatient hospital care is the **sum insured specified in the certificate of coverage or indexation offer letter** in force during the period of the hospitalization **multiplied by the number of hospitalization days.**

If the insured suffers an accident while the insurance policy is in force but **is hospitalized** due to such accident **only after the termination of this insurance policy,** the benefit payout will be determined based on the **sum insured stated in respect of this risk in the certificate of coverage effective as of the date of the insured event, or in the indexation offer 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 license.

For the purposes of these policy conditions, treatment in an intensive care unit (ICU) does not include treatment in a sub intensive care unit (SICU) or ward, or in a post-anesthesia care unit (PACU).

II.4. **If** the insurance policy's anniversary date occurs during a period when the insured receives inpatient hospital care, and the **insurance policy is subject to annual indexation** (within the meaning of Clause IV.4. of the general conditions), the insurance company **shall apply the increased sum insured** to determine the benefit payout **after the policy anniversary,** in accordance with the rules of annual indexation.

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy of the following documents:**
- a) the hospital discharge summary;
- b) the discharge summary issued by the intensive care unit, if such treatment was provided;
- c) all medical documents related to 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 result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim on the basis of the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

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

Under this insurance policy, the insurance company will be relieved from the payment of the accidental hospital 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 Accidental Surgery Insurance (EBMÜT022)

These special 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

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 the result of which the **insured has a surgery** (within the meaning of Clause IX.5. of the general conditions) provided that the surgery is medically required.

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

II. INSURANCE BENEFIT

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

II.2. The insurance benefit is the given **percentage of the sum insured stated in respect of this risk in the certificate of coverage effective as of the date of the surgery – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter, depending on the surgery performed.** If the surgery is performed **after the termination of this insurance policy** but **within two years after the date of the accident referred to as the insured event,** the insurance benefit payout will be based on the **sum insured stated in respect of this risk in the last effective certificate of coverage, or in the indexation offer letter.**

II.3. The classification of **operations** is set out in the **List of Surgeries** in Schedule A 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 more than one surgery is 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 **(that is with the highest percentage of benefit payment).**

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) the hospital discharge summary;
b) the operative report, if available;
c) all medical documents related to 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 result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

IV. EXEMPTION OF THE INSURANCE COMPANY FROM PAYMENT OF BENEFITS, EVENTS EXCLUDED FROM THE INSURANCE 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 Burns Insurance (EBÉGS022)

These special 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

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

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

II. INSURANCE BENEFIT

II.1. **The insurance company shall pay the % of the sum insured stated in respect of this risk 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 offer letter, corresponding to the severity of the burns.**

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

Depth	Body surface area			
	10–19%	20–49%	50–79%	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 the 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 the head (facial skull or cranial skull, including the ear and the sub-neck region of the chin) of at least 2% of the total body surface,** the insurance company will pay the insured **200% of the sum insured stated** in respect of this risk **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 offer letter.**

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

II.6. **The insurance payout may be maximum 200% due to the same insurance event.**

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy 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 related to the insured event from its occurrence until the notification of the insurance claim,
c) the accident & injury report, or the workplace A&I report if one was made,
d) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **In the event of death, a copy of the following documents shall also be submitted when the claim is made:**
a) cause of death medical certificate /hospital course summary,
b) the insured's certificate of death,
c) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.
d) documents required for a clarification of the circumstances of the death - or the accident,

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 based on the findings of such review.**

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

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

Under this insurance policy, the insurance company will be relieved 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 Accidental Incapacity Insurance (EBKEK022)

These special conditions set out the standard terms and conditions for the **accidental incapacity 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

I. INSURED PERSON

I.1.a) A **natural person who** is **not entitled to statutory sick pay** under the compulsory health insurance scheme in his/her own right **cannot be insured** under these special conditions.

b) Before accepting the insurance application, the insurance company may request written proof that the insured is entitled to statutory sick pay under the compulsory health insurance scheme, i.e. it may request proof that the insured pays the cash sickness insurance contribution specified in Act LXXX of 1997.

I.2. The **insured must** notify the insurance company in writing **within 15 days:**

a) after the occurrence, if his/her **entitlement to the statutory sick pay** under the compulsory health insurance scheme ceases **during the term of the policy** subject to these special conditions.
In this case, the accidental incapacity insurance cover of the insurance policy will terminate on the first day of the month following the month in which the entitlement to the statutory sick pay ceases.

b) upon receipt of the resolution of the National Pension Insurance Administration, **if he/she becomes entitled to old-age pension, disability, accidental disability or rehabilitation allowance or other pension-like benefits (hereinafter collectively referred to as 'pension') during the term of the policy.**
In such a case the accident-related incapacity insurance coverage of the insurance policy will terminate on the first day of the month following the date of the insured's pension eligibility.

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

II. INSURED EVENT

II.1. An insured event is an **accident** (within the meaning of Clause IX.1 of the general conditions) which occurs **during the coverage period,** as **a result of which the insured is continuously unable to work** (continuously incapacitated), **in his/her own right,** for a **maximum of 2 years from the date of the accident,** as **certified by a physician** authorized to assess and certify incapacity for work in accordance with the Hungarian legislation in force, and is receiving statutory sick pay in Hungary.

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

III. INSURANCE BENEFIT

III.1. The insurance covers the **insured's incapacity period due to medical consequences arising from an accident of the insured within two years after the date of the accident.**

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

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

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

III.5. If the policy anniversary falls within a period when the insured is certifiably incapacitated within the meaning set out herein, and the **insurance policy is taken out with annual indexation** (Clause IV.4. of the general conditions), the insurance company shall pay to the insured an increased benefit set out in the indexation offer letter in respect of this insurance cover from the anniversary date of the insurance.

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

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

IV.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) a standard form issued by a physician authorized to certify incapacity for work, in accordance with the legislation in force (Medical certificate of incapacity for work (pregnancy));
b) if the insured was hospitalized: the hospital discharge summary, within 15 days after the end of the hospital treatment;
c) all medical documents produced in connection with the insured event from the occurrence of the accident until filing the insurance claim;
d) the accident & injury report, or the workplace accident & injury report, if one was made,
e) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

IV.4. **In any continuing period of incapacity:**

– the documents listed in Clause 3.1. and Clause 3.2. d), e), f) of this Chapter are required to be submitted only with the first claim;
– a copy of the medical certificate on the insured's continuing period of incapacity issued by a health care provider authorized to assess incapacity pursuant to effective legislation, shall be submitted to the insurance company within 14 days after it is issued, with reference to the policy number (hereinafter: medical certificate on a continuing period of incapacity);
– new physician's certifications on the insured's medical conditions are required to be submitted by the insured to the insurance company at least once in every 60 days.

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

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

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

V.1. In the case of this insurance policy, the insurance company will be relieved from the payment of the incapacity 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.

V.2. In addition to the exclusions set out in the general conditions, the insurance company shall not be liable for the insured's incapacity for work during which the insured pursues earning activities.

Special Conditions of Road Accident Death Insurance (EKHAT022)

These special conditions set out the standard terms and conditions for the **road accident 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

I. INSURED EVENT

I.1. The insured event is a road traffic accident (within the meaning of Clause IX.2 of the general conditions) which occurs during the coverage period and as a result of which the insured dies within one year after such accident.

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

II. INSURANCE BENEFIT

If the **insured dies as the result of a road accident while this insurance policy is in force,** and the insurance claim is grounded, the insurance company **pays to the beneficiary of the death benefit the sum insured stated in respect of this risk in the certificate of coverage effective as of the date of death, or in the indexation offer letter, and as a result, the insurance policy will terminate.**

If the **insured dies after the termination of this insurance policy as a result of a road traffic accident** which occurred while the insurance policy was in force, but the insured's death is within one year after the date of the road traffic accident specified as the insured event, the insurance benefit payout will be determined on the basis of the **sum insured specified in respect of this covered risk on the last certificate of coverage in force, or in the indexation offer 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) cause of death medical certificate /hospital course summary,
b) autopsy report;
c) the death certificate of the insured;
d) 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;
e) the official record of the transport company, police, workplace, if any, taken on the spot;
f) the result of the blood alcohol and/or drug test, if one was administered,
g) if the insured person **was injured** in a traffic accident as **the driver of the vehicle,** the insured's driving license and the vehicle's registration certificate;
h) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the death benefit due to a road accident in the cases described in Chapter VII of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

Special Conditions of Road Accident Permanent Disability Insurance with Linear Benefit Payment (EKROK022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is a **road traffic accident** (within the meaning of Clause IX.2 of the general conditions) which occurs while the insurance policy is in force and **as the result of which the insured suffers permanent disability.**

I.2. **For the purposes of this insurance, disability** is defined as a **reduction in physical and/or mental functioning that limits the ability to lead a normal life.**

I.3. **Disability is permanent** if the **medical condition** of the insured is **unchanging or stable.** If **the degree of the disability is still constantly changing,** but 2 years have passed since the date of the accident, then **after 2 years from the date of the accident, the medical expert of the insurance company will determine the degree of the disability, which the insurance company** will **consider as permanent disability** as the result of the accident for the purposes of determining the amount of the benefit. **A change in the insured's earning capacity and/or the need to terminate his/her sports activity cannot be used as a binding reference** for establishing permanent disability. **No adverse aesthetic effect or other (social, financial, etc.) detriment** caused by the accident **shall in itself be grounds for an insurance claim for permanent disability (health impairment).**

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

II. INSURANCE BENEFIT

II.1. **The insurance company will only pay the insurance benefit if the disability is** confirmed to be **permanent** (within the meaning of Clause I.3. of these special conditions).

II.2. **If an insured event occurs, the insurance company shall pay a percentage of the sum insured stated in respect of this covered risk in the certificate of coverage effective as of the date of when the extent of the permanent disability was established – or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter, corresponding to the extent of the permanent disability,** subject to Clause II.9 of these special conditions.

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

II.4. If the extent of the impairment **cannot be established based on the table,** it 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 the disability determined in the expert's opinion of the **National Institute of Medical Experts** (or the body authorized by the effective legislation to determine a degree of disability (health impairment)) and/or in the **resolution of the National Pension Insurance Administration cannot be used as a binding reference** for determining the extent of the disability by the insurance company's physician-expert, or for determining the amount of the benefit payable by the insurance company. **Furthermore, no expert opinion or resolution of any other medical expert board may be used as a reference binding the insurance company in determining the permanent nature of the impairment or the extent thereof.**

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

II.6. **If the insured dies before his/her disability (health impairment) could become permanent, the benefit shall be determined on the basis of the extent of the disability confirmed by the insurance company's physician on the basis of the documents of the last medical examination.**

II.7. **No claim on permanent disability** may be made **if the insured dies within 15 days after the accident.**

II.8. **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.9. **If the insurance company has already made a benefit payout and subsequently the condition of the insured continues to deteriorate as a result of the same insured event, the insured may file a supplementary insurance claim, supported by all the necessary medical documents in proof of the deterioration of the insured's condition** despite appropriate medical treatment, once a year, for a maximum of 4 years for each insured event after the date of the accident which was reported in the first insurance claim, and **may request that his/her condition be reassessed and the extent of the permanent disability be determined again.** Based on the findings of the medical review, the insurance company shall settle the claim in accordance with Clause II.2 of these policy conditions, on the understanding that **any benefit payouts made earlier on the same insured event shall be deducted from any later benefit payout.**

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

III.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy 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 police report, if one was prepared,
c) the official on-site report of the passenger carrier company, if one was made,
d) the result of the blood alcohol and/or drug test, if one was administered,
e) if the insured person **was injured** in a traffic accident as **the driver of the vehicle,** the insured's driving license and the vehicle's registration certificate;
f) other documents required to clarify the circumstances of the accident.

III.4. **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 based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

III.6. 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 **permanent disability which has been medically confirmed,** the insurance company shall make the payout **within 15 days upon receipt of the last document,**
b) in other cases, the insurance company shall make the payout **within 15 days after the disability is confirmed to be permanent,** or **within 15 days after the expiry of 4 years following the accident.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the permanent disability benefit due to road 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 Accident Expenses Insurance (EBKTS022)

These special 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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

I. INSURED EVENT

I.1. The insured event is **an accident** (within the meaning of Clause IX.1 of the general conditions) which occurs while the insurance policy is in force, as the result of which the **insured incurs accident expenses as defined in Clause I.2.**

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

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

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 the 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) the repair costs of **teeth, dentures, crowns, bridges, and other dental appliances injured or damaged in the accident,** except for removable dentures, provided that the damage is proven to be the result of the accident. Accident expenses 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 the result of an accident, as well as the costs of outpatient medical examinations, treatments and diagnostic tests **not financed 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 BENEFITS AND LIMITATIONS TO BENEFIT 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 offer 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 of 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 in respect of this risk 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 offer letter.**

In respect of any one insured event, the insurance company's payment to 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 offer 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

III.3.3. **and a copy 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, or the workplace A&I report, if one was made;
c) the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.
e) other documents required to clarify the circumstances of the accident.

III.4. **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 based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

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

Under this insurance policy, the insurance company will be relieved 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 Hospitalization Insurance with Daily Allowance (EEKNT022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

I. INSURED EVENT

I.1. The insured event is **the insured's sudden illness which is unprecedented relative to the commencement of the insurance coverage or an accident** (Clauses IX.1. and IX.3 of the general conditions) **which occurs during the coverage period,** as the result of which the **insured needs to be hospitalized** (Clause IX.4. of the general conditions) **and receives in-patient care,** if 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 day 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 Policy Conditions), the first day of hospitalization shall be the date of admission, and the last day of hospitalization shall be the date of **discharge.**

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

II. INSURANCE BENEFIT

II.1. In the event of the **insured's illness,** the insurance pays out the insurance benefit for **each day** (Clause I.2. of these policy conditions) **of the insured's inpatient hospital care during the coverage period.** If the insured **has an accident** while the insurance policy is in force, the insurance company shall pay the insurance benefit for **each day** (Clause I.2. of these policy conditions) **of the insured's inpatient hospital care** required to treat medical consequences of the accident **within two years after the date of the insured's accident.**

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

If the insured suffers an accident while the insurance policy is in force but **is hospitalized** due to such accident **only after the termination of this insurance policy,** the benefit payout will be determined based on the **sum insured stated in respect of this risk in the certificate of coverage effective as of the date of the insured event, or in the indexation offer 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 license.

For the purposes of these policy conditions, treatment in an intensive care unit (ICU) does not include treatment in a sub intensive care unit (SICU) or ward, or in a post-anesthesia care unit (PACU).

II.4. If the insurance policy's renewal date is during a period when the insured receives inpatient hospital care, and the **insurance policy is subject to annual indexation** (within the meaning of Clause IV.4. of the general conditions), the insurance company **shall apply the increased sum insured** to determine the benefit payout **after the renewal date** of the insurance policy, in accordance with the rules of annual indexation.

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. The insurance claim shall be notified to the insurance company **in writing within 15 days** after the insured is discharged from the hospital.

III.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company may be exempted from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy of the following documents:**
a) the hospital discharge summary;
b) the discharge summary issued by the intensive care unit, if such treatment was provided;

c) **in the event of inpatient care in a hospital due to an accident,** additionally:
   - all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
   - the accident & injury report, or the workplace accident & injury report if one was made,
   - the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the hospitalization daily allowance 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 Surgery Insurance (EEMÜT022)

These special conditions set out the standard terms and conditions for the **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 the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is **the insured's sudden illness which is unprecedented relative to the commencement of the insurance coverage or an accident** (Clauses IX.1. and IX.3 of the general conditions) **which occurs during the coverage period,** as the result of which the **insured needs surgery** (Clause IX.5. of the general conditions) provided that the surgery is a medical necessity.

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

II. INSURANCE BENEFIT

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

II.2. **The 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 offer letter, **corresponding to the category of the surgical procedure performed.** If the surgery – **required as the result of** the insured person's **accident** – is performed **after the termination of this insurance policy but within two years after the date of the accident referred to as the insured event,** the insurance benefit payout will be based on the **sum insured stated in respect of this risk in the last effective certificate of coverage, or in the indexation offer letter.**

II.3. **The classification of operations is set out in the List of Surgeries in Schedule A 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 more than one surgery is 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 **(that is with the highest percentage of benefit payment).**

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) the hospital discharge summary;
b) the operative report, if available;
c) additionally, if the insured event is the result of an accident:
   – all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
   – the accident & injury report, or the workplace accident & injury report if one was made,
   – the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driver license and the vehicle registration certificate.

III.4. **The insurance company shall be entitled to have the reasonableness of the insured's medical treatment and the insured's medical conditions confirmed by physicians designated by the insurance company, and to approve or deny the insurance claim based on the findings of such review.**

III.5. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

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

In the case of this insurance policy, the insurance company will be relieved from the payment of the 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 Malignant Tumor Insurance (EERDB022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT

I.1. The insured event is a **sudden, unexpected onset of a malignant tumor any time during the coverage period, without precedent conditions prior to the commencement of the insurance coverage.**

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

For the purposes of these special conditions, malignant tumors include: malignancies include malignant tumors of hematopoietic tissues (leukemias), tumors of the reticuloendothelial and lymphatic system (lymphomas), malignant plasma cell disorders (plasma cell myeloma).

The insurance does not cover the following groups of malignant tumors:
- premalignant (pre-carcinoma) conditions,
- non-invasive (in situ) tumors,
- skin cancer, except malignant tumors of melanocytes (malignant melanoma),
- any tumor that develops following a diagnosis of HIV.

I.2. The **date of the insured event** is the date of the diagnosis of a malignant tumor of the insured person.

II. INSURANCE BENEFIT

II.1. If an insured event occurs, the **insurance pays out the sum insured stated in respect of this risk in the certificate of coverage effective** as of the date of the insured event **or in the indexation offer letter, and at the same time the malignant tumor insurance coverage of the policy will terminate.**

II.2. If **the insurance benefit** defined in Clause II.1. of these special conditions is not claimed and paid out **while the insured is alive,** and **in the opinion of the insurer's medical expert the death of the insured resulted from any of the illnesses listed in Clause I.1. of these special conditions,** the insurance company will **pay to the death beneficiary** the **sum insured specified in respect of this risk in the certificate of coverage effective as of the date of the insured's death, or in the indexation offer letter.**

II.3. Pursuant to these special conditions, the **insurance company shall pay the sum insured as an insurance benefit only once** with respect to the same insured, even if the insured has **more than one of the illnesses** listed under Clause I.1. of these special conditions **at the same time or one after another,** and irrespective of the fact whether the illness(es) listed under Clause I.1. of these special conditions has (have) been diagnosed in the life of the insured, or the causal link between the illness(es) and the death has been established after the insured's death.

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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

III.3.2. **and a copy of the following documents:**
a) the hospital discharge summary,
b) if a surgery was performed, the operative report, if one was made.
c) a copy of the positive histological confirmation (describing the malignant nature of cells and their invasive growth).

III.4. **In the case of death due to a malignant tumor, a copy of the following documents shall also be submitted:**
a) cause of death medical certificate /hospital course summary,
b) the insured's certificate of death,
c) the medical documents in proof of the date of the first diagnosis and describing the progression of the illness which led to the insured's death, as well as any other documents required for clarification of the circumstances of the death (physician's certification, hospital discharge summary, pathology report, etc.),
d) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

III.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 based on the findings of such review.**

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

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

IV.1. Under this insurance, the insurance company will be relieved from the payment of the malignant tumor benefit in the cases described in Chapter VI of the General Conditions, and the insurance does not cover the cases listed in Chapter VII of the General Conditions.

IV.2. For the purposes of these special conditions, notwithstanding the provisions set out in Clause VII.1.1. c) of the general conditions, the insurance covers HIV infection, save for the case when the insured was already demonstrably infected by HIV at the time when the insurance application was submitted.

Special Conditions of 40 Critical Illnesses Insurance (EEDRD022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED EVENT, DATE OF THE INSURED EVENT

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

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

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

1. **Myocardial death** (heart attack) is the death of a part of the heart muscle due to a sudden loss of blood supply to the dead area. For the purposes of these special conditions, only those pathological conditions shall be regarded as myocardial infarction, where the extent of the tissue damage results in abnormal Q waves which may be visualized by standard ECG registration techniques.
   The date of the insured event: the time of the onset of the illness, as determined by the attending physician.

2. In the case of **malignant neoplasms,** there is uncontrolled growth of cells showing signs of histological atypia (malignant cells), with the possibility of malignant cells spreading across tissue boundaries (invasion) and the potential for malignant cells to colonize, proliferate and invade distant organs (metastasis).
   For the purposes of these special conditions, malignant tumors include: malignancies include malignant tumors of hematopoietic tissues (leukemias), tumors of the reticuloendothelial and lymphatic system (lymphomas), malignant plasma cell disorders (plasma cell myeloma).

The insurance does not cover the following groups of malignant tumors:
- premalignant (precancerous) conditions,
- tumors that do not spread to the surrounding area (in situ),
- skin cancer, excluding malignant tumors of the pigmented moles (melanoma malignum),
- any tumor that develops following a diagnosis of HIV.

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

3. **Cerebrovascular accident** is a pathological condition (rupture of the vascular wall, total or partial blockage of a vessel due to thrombosis or embolism) in the intracranial vessel, resulting in necrosis, infarction and permanent organ and nervous system damage (so-called plexus injuries) of the central nervous system areas supplied by the vessel, i.e. physical symptoms indicating damage are clearly detectable even 30 days after the onset of the vascular accident or stroke. **The insurance does not cover a cerebrovascular accident where there is a causal link to an accident** within the meaning of Clauses IX.1. and IX.2. of the general conditions.
   The diagnosis of the **cerebrovascular accident,** the permanent neurological deficit, and the causal link between the two shall be **determined by the medical expert of the insurance company, or a specialist consultant appointed by the medical expert.**
   The date of the insured event: the date determined as the onset of the illness, provided that the physical symptoms indicative of the permanent damage to the nervous system are present even after 30 days following the onset of the illness.

4. **Chronic renal failure** is a condition where the function of both kidneys is irreversibly reduced and this reduction is such that the condition is incompatible with life without artificial kidney treatment or transplantation, and the insured requires dialysis treatment for at least 60 days from the start of dialysis.
   The date of the insured event: the first day of the renal dialysis, provided that the insured needs to receive dialysis for at least 60 days.

5. **Coronary artery surgery** is an open-chest procedure to remove a narrowing or blockage of two or more vessels, as evidenced by coronary angiography, by removing the diseased vessel segment and replacing it with a vessel from another part of the body or by bridging the diseased vessel segment.
   The date of the insured event: the date of the surgery.

6. **Organ transplantation** is a surgical procedure in which a heart, heart-lung complex, lung, liver, or kidney is transplanted from the body of the recipient (donor) into the body of the recipient (recipient). **Tissue and cell transplants are not included in the definition of organ transplantation; therefore pancreas, skin and bone marrow transplants and transfusions are not covered.**
   The date of the insured event: the date of the surgery.

7. **AIDS** is a condition in which the CD4+ (lymphocyte) cell count in the blood of an HIV-infected person remains persistently below 200/il and opportunistic infection occurs, caused by otherwise harmless pathogens present in humans.
   The date of the insured event: the date of the diagnosis of the disease.

8. **Benign tumor** is a brain or spinal cord tumor confirmed as benign by an advanced diagnostic method (CT/MR), which results in complete paralysis of one limb even after 6 months after the end of treatment.
   The date of the insured event: the date of the diagnostic procedure confirming the disease.

9. **Pacemaker-defibrillator implant** means the permanent pacemaker and defibrillator implantation surgery required due to conduction disturbance and ventricular fibrillation.
   The date of the insured event: the date of final pacemaker and defibrillator implant surgery.

10. **Arteriosclerosis (coronaria sclerosis)** is the narrowing of three coronary arteries to the extent that it has been confirmed by cardiac catheterization to require revascularization, but the main coronary artery (LAD) supplying the left ventricle is not suitable for any intervention or surgery based on medical documentation.
    The date of the insured event: the date of the cardiac catheterization.

11. **Artificial heart implantation**
    Artificial heart surgery is a medical surgical procedure where an artificial heart is implanted permanently into the patient's body to replace permanently impaired heart function, and the artificial heart performs its function for 30 days after the surgery. An external cardiac motor used during surgical procedures or a temporary intra-aortic cardiac pump treatment is not considered an artificial heart.
    The date of the insured event: the date of the surgery.

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

13. **Cardiomyopathy** is defined as a myocardial disease in which the cardiac output (EF) does not exceed 20% for at least 6 months continuously with treatment.
    The insurance does not cover cardiomyopathy if it is developed due to alcohol and drug consumption.
    The date of the insured event: the date of the diagnosis of the disease.

14. **Cerebrovascular surgery** is surgery on a cerebral or cerebrospinal vessel that involves opening the neurocranium because of a disease. It shall not be deemed as an insured event if a surgery is required by reason of an accident or for the sole purpose of cranial cavity pressure reduction.
    The date of the insured event: the date of the surgery.

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

16. **Aorto-bifemoral bypass surgery** is defined as bypass surgery performed on both femoral arteries in one procedure due to a stenosis. Surgery for atherosclerosis caused by a stenosis of the coronary arteries which is diagnosed within 6 months of the commencement of coverage, or an operation performed using a vascular catheter technique, is not considered an insured event.
The date of the insured event: the date of the surgery.

17. **Alzheimer's disease** (AD) is defined as a neurological disease of a severity characterized by a progressive deterioration of mental faculties, behavioral disorders, and biological degradation following dementia, and as the result of which the National Institute of Medical Experts has determined the extent of the insured's disability to be more than 49% due to this disease alone.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

18. **Parkinson's disease** (PD) is defined as a progressive neurological disease characterized by involuntary movements manifested by tremor, muscle tension, slowness of movement, imbalance; and as the result of which the National Institute of Medical Experts has determined the extent of the insured's disability to be more than 49% due to this disease alone.
The insurance does not cover a disease diagnosed as Parkinson's syndrome (caused by e.g. medication, toxic injuries, or arteriosclerosis).
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

19. **Multiple sclerosis** (MS) is a demyelinating progressive disease causing neurological and psychic symptoms, as the result of which the National Institute of Medical Experts has determined the extent of the insured's disability to be more than 49% due to this disease alone.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

20. **Loss of hearing** is defined as a permanent hearing loss of at least 91 Db in both ears, which is permanent and cannot be corrected by surgery or assistive devices, and which has persisted for at least 6 months as the result of illness or accident.
The date of the insured event: the date of the medical specialist examination document of otorhinolaryngology establishing loss of hearing on both sides, considering their status as final, and recording audiogram test results as well.

21. **Loss of vision** occurs when the vision in both eyes is irreversibly impaired due to illness or accident, has been irreversibly impaired for at least 6 months, is irreversibly impaired beyond correction, to the extent that the remaining visual field in either eye is less than 10% due to visual field loss and/or both eyes only detect hand movement due to visual acuity loss, or the combined visual field loss and visual acuity loss result in a visual acuity loss (VA loss) of 100% and the expert opinion of the National Institute of Medical Experts confirms the above.
The date of the insured event: the date of the ophthalmological examination document confirming the insured event and describing the condition as definitive.

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

23. **Aplastic anemia** occurs if the disease is confirmed by hematological opinion based on bone marrow examination and the treatment has been continuous for at least 1 year with at least 4 units of transfusion (blood replacement) per month. Blood products given for other conditions or accidents are not included in this amount.
The date of the insured event: the date of the first transfusion as specified in the definition of the insured event.

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

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

26. **Hepatitis C virus** infection is considered an insured event if, after the end of antiviral or other therapeutic treatment, the hepatology institute that provided the treatment documents the persistence of Hepatitis C virus infection and liver cirrhosis due to liver damage, associated with esophageal varicosity and abnormal liver function results, and no further outpatient treatment is possible.
The date of the insured event: the date of the medical specialist examination document of hepatology supporting the insured event.

27. **Severe burns** occur when heat causes third-degree burns affecting at least 20% of the total body surface, and the insured requires medical treatment for more than 30 days after the date of the burn injuries.
The date of the insured event: the date of the accident.

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

29. **Familial adenomatous polyposis** (FAP) is considered an insured event if the disease results in the removal of the entire colon and the concomitant development of a permanent ileostomy.
The date of the insured event: the date of the surgery.

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

31. **Small bowel surgery** is considered an insured event if at least half of the small intestine has been removed, for any reason, supported by a surgical description (operative report) and histology records.
The date of the insured event: the date of the surgery.

32. **Nephrostomy surgery** is considered an insured event if a definitive nephrostomy was prepared on both sides at least 6 months ago.
The date of the insured event: the date of the second or simultaneous bilateral nephrostomy preparation.

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

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

35. **Ankylosing spondylitis (Bekhterev's disease)** is deemed to be an insured event if the severity thereof is qualified in the expert opinion of the National Institute of Medical Experts corresponding to more than 69% of disability only due to this spine disease.
The date of the insured event: The issue date of the expert opinion of the National Institute of Medical Experts.

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

37. **Facial nerve paralysis** occurs when the facial nerve (Nervus facialis) is paralyzed to the extent that feeding is impossible due to a disturbance in the closure of the mouth, and as the result of this, gastric or small bowel feeding tubes have been continuously inserted through the abdominal wall (stoma) for at least 6 months.
The date of the insured event: the date of implantation of the stomach or small intestine tube.

38. **Esophageal stricture** occurs when the narrowing of the esophagus due to a non-cancerous disease is so severe that it has been the cause of continuous gastric or gastrointestinal tube feeding through the abdominal wall for at least 6 months.
Date of insured event: the date of implantation of a stomach or small intestine probe (gastrostomy, jejunostomy).

39. **Constrictive pericarditis** is deemed to be an insured event if open thoracic pericardial surgery has been performed for treatment.
The date of the insured event: the date of the surgery.

40. **Chronic acquired skin inflammation** (e.g. allergic or irritative contact skin inflammation, atopic dermatitis, psoriasis) is deemed to be an insured event if such inflammation – in spite of treatment directed by a dermatologist – has been continuously affecting, in an active state, at least 50 % of the surface of the body, both palms and both soles for at least 1 year at the time of the notification of the claim for benefit.
The date of the insured event: the date of the diagnosis of the disease.

II. INSURANCE BENEFIT

II.1. If an insured event occurs, the **insurance company will pay the sum insured stated in respect of this risk 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 offer letter, and the part of the insurance policy relating to the critical illness cover will be terminated.**

II.2. If the **insurance benefit** defined in Clause II.1. of these special conditions is not claimed and paid out **while the insured is alive, and in the opinion of the insurer's medical expert the insured event resulted from any of the illnesses listed in Clause I.1. of these special conditions,** the sum insured **set out in respect of this risk in the certificate of coverage or indexation offer letter** in force at the time of death **will be paid to the beneficiary entitled to the death benefit.**

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

III. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

III.1. 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 respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

III.3.3. **and the documents specified below:**

1. **in the case of myocardial infarction**
   a) an ECG abnormality suggestive of recent myocardial infarction (for the purpose of these specific conditions, only myocardial infarctions in which the abnormal, previously undetected Q wave – width greater than 40 ms, amplitude greater than 25% of the amplitude of the R wave – in any lead of the conventional 12-lead ECG recording in causal relation to the coronary occlusion shall be covered) and

b) a pathological increase in so-called myocardial-specific enzyme levels – a significant, well-documented increase in the levels of any intracellular enzyme (CPK, CKMB, SGOT, LDH, alpha-HBDH) should be considered as a fulfilment of this condition.

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

3. **in the case of a cerebrovascular accident**
a copy of medical documents showing symptoms of organ-nerve damage in the central nervous system causally related to the cerebrovascular accident, which are still present 30 days after the cerebrovascular accident and which can be certified.

4. **in the case of chronic renal failure**
a copy of the medical documents in proof of the regular dialysis of the insured for at least 60 days, issued by the medical institution that performed the dialysis.

5. **in the case of a coronary artery surgery**
a copy of the hospital discharge summary certifying that the surgery was carried out.

6. **in the case of an organ transplantation**
a copy of the medical document confirming the surgical procedure.

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

8. **in the case of a benign tumor**
   a) the document of the diagnostic procedure diagnosing the disease,
   b) the results of the neurosurgery or neurology control check to support the insured event, performed at least 6 months after treatment completion.

9. **in the case of a pacemaker-defibrillator implant surgery**
all documents produced in relation to the cardiovascular disease,

10. **in the case of arteriosclerosis**
    a) all documents produced in relation to the cardiovascular disease,
    b) documentation of cardiac catheterization.

11. **in the case of artificial heart implantation**
    a) all documents produced in relation to the cardiovascular disease,
    b) the hospital discharge summary of the artificial heart implantation, and
    c) the result of a cardiological examination at least 30 days after the operation.

12. **In the case of a heart valve surgery**
    a) all documents produced in relation to the cardiovascular disease,
    b) the hospital discharge summary confirming the open thoracic surgery,
    c) results of the cariology control check performed at least 30 days after the surgery.

13. **In the case of cardiomyopathy**
the complete cardiological documentation, including documents on the 6 months preceding the notification of the claim for benefit.

14. **in the case of cerebrovascular surgery**
all medical documents produced in relation to the illness which required the undergoing of surgery.

15. **in the case of an open thoracic and/or abdominal aorta repair**
all medical documents produced in relation to the illness which required the undergoing of surgery.

16. **in the case of an aortobifemoral bypass surgery**
all medical documents produced in relation to the illness which required the undergoing of surgery.

17. **in the case of Alzheimer's disease (AD)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the National Institute of Medical Experts.

18. **in the case of Parkinson's disease (PD)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the National Institute of Medical Experts.

19. **in the case of Multiple sclerosis (MS)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the National Institute of Medical Experts.

20. **in the case of the loss of hearing**
    a) all medical documents produced in relation to the loss of hearing,
    b) the audiograms evidencing the occurrence of the insured event.

21. **in the case of the loss of vision**
    a) all medical documents produced from the commencement of visual deterioration to the notification of the insurance claim,
    b) the expert opinion of the National Institute of Medical Experts.

22. **in the case of the loss of speech**
    a) all medical documents produced from the loss of speech to the notification of the insurance claim,
    b) the expert opinion of the National Institute of Medical Experts.

23. **in the case of aplastic anemia**
    all medical documents produced in relation to the illness, including documentation on transfusions.

24. **In the case of hemophilia**
    all medical documents produced in relation to the illness, including documentation on factor supplementation.

25. **In the case of Osler disease**
    all medical documents produced in relation to the illness, including documentation on transfusions.

26. **In the case of Hepatitis C virus infection**
    all medical documents produced in relation to the illness.

27. **in case of severe burns**
    all medical documents produced in relation with the accident, including any medical documents on treatment from the date of the accident to any date beyond the 30th day after the date of the accident.

28. **In the case of ulcerative colitis**
    a) all medical documents produced in relation to the illness,
    b) the surgery discharge summary with the operative report.

29. **in the case of familial adenomatous polyposis (FAP)**
    a) all medical documents produced in relation to the illness,
    b) the surgery discharge summary with the operative report.

30. **in the case of Crohn's disease**
    a) all medical documents produced in relation to the illness,
    b) the surgery discharge summary with the operative report.

31. **in the case of small bowel surgery**
    a) all medical documents produced in relation to the illness,
    b) the surgery discharge summary with the operative report as well as the histological confirmation.

32. **in the case of a nephrostomy surgery**
    a) all medical documents produced in relation to the illness, including the results of the urology control check performed at least 6 months of surgery,
    b) the surgery discharge summary with the operative report.

33. **In the case of end-stage pulmonary disease**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the National Institute of Medical Experts.

34. **in case of rheumatoid arthritis (RA)**
    a) all medical documents produced in relation to the illness,
    b) the expert opinion of the National Institute of Medical Experts.

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

36. **in case of amputation**
    hospital discharge summary/summaries and operative report/s in relation to the amputations.

37. **in the case of facial nerve paralysis**
    all medical documents relating to the illness, including the results of a follow-up examination at least 6 months after the surgery.

38. **In the case of esophageal stricture**
    all medical documents relating to the illness, including the results of a follow-up examination at least 6 months after the surgery.

39. **In the case of constrictive pericarditis**
    all medical documents produced in relation to the illness, including documentation on the cardiology examination preceding the surgery.

40. **In the case of chronic acquired skin inflammation**
    all medical documents from the time the disease is diagnosed until the date of the insurance claim, including medical records of treatment referred by a dermatologist authorized to treat the disease.

III.4. **In the event of death resulting from any of the insured events covered in these Special Conditions, a copy of the following documents shall also be submitted:**
    a) cause of death medical certificate /hospital course summary,
    b) the insured's certificate of death,
    c) the medical documents in proof of the date of the first diagnosis and describing the progression of the illness which led to the insured's death or the **underlying disease leading to surgery,** as well as any other documents required for clarification of the circumstances of the death (physician's certification, hospital discharge summary, pathology report, etc.),

d) **the document certifying the beneficiary's entitlement to the insurance benefit** (a binding grant of probate or a certificate of inheritance, court decision), provided that the beneficiary was not named in the insurance policy.

III.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 based on the findings of such review.**

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

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

IV.1. In the case of this insurance policy, the insurance company will be relieved from the payment of the critical illness benefit in the cases described in Chapter VI of the general conditions, and the insurance does not cover the cases listed in Chapter VII of the general conditions.

IV.2. For the purposes of these special conditions, notwithstanding the provisions set out in Clause VII.1.1. c) of the general conditions, the insurance covers HIV infection, save for the case when the insured was already demonstrably infected by HIV at the time when the insurance application was submitted.

Special Conditions of Tumor Diagnostics Insurance (EEDAD022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

This insurance can only be taken out in conjunction with the 40 Critical Illnesses cover or the Malignant Tumor cover, and in the event of their termination, the insurance cover offered under these special conditions will also terminate.

I. INSURED EVENT

I.1. The insured event is a sudden, **unexpected development of symptoms or morbidity** without related conditions existing prior to the commencement of the insurance coverage during the coverage period, as **a result of which the insured is tested for tumor markers by a specialist of the particular medical specialty or by the insured person's General Practitioner,** and based on the positive results of the cancer specific diagnostic test (suspected malignancy) **there is a reason to suspect a malignant tumor.**

I.2. The insurance does not cover the following groups of suspected malignant tumors:
- any suspected malignancy in HIV-infected patients,
- suspected malignancy as a recurrence of a previous malignant tumor,
- suspected skin cancer, except malignant tumors of melanocytes (malignant melanoma),
- suspected malignancy based on genetic testing.

I.3. When a malignant melanoma is clinically suspected the tumor, specific diagnostic test may be replaced by a medical opinion drawn up by a dermatology specialist requiring further tests to confirm the suspected malignant melanoma.

I.4. For the purposes of this insurance, only imaging tests, endoscopic examinations, histological or cytological examinations, elevated tumor marker levels, performed prior to the commencement of the insurance coverage are considered diagnostic tests specific to cancer (except I.3).

For the purposes of these conditions, an elevated level of a tumor marker shall be regarded as a tumor-specific diagnostic test when performed pursuant to a patient-reported symptom or a clinician's medical opinion.

For the purposes of these conditions tumor specific diagnostic tests shall not include thermography, thermal imaging, bio resonance testing results and other non-conventional testing procedures.

II. DATE OF THE INSURED EVENT

II.1. The date of the insured event is the date of the medical document describing the suspected malignant tumor based on the results of a specific diagnostic test.

II.2. If the insured event takes place during the waiting period, this insurance does not pay out.

III. INSURANCE BENEFIT

If an insured event occurs, **the insurance will cover the cost of** the following **services** provided by the insurance company's health care service partner **up to the amount of 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 offer letter.**

III.1. Prompt and complex diagnostics depending on the type of tumor suspected
- specific medical assessment of the insured's condition
- oncology testing and consultancy, tailored medical work-up recommendation,
- prompt and full-scale **arrangement and delivery of modern diagnostic tests** (PET CT, molecular diagnostic tests) which may be medically reasonable in respect of the type of tumor suspected, **including additional testing required for the oncology treatment in relation to any comorbidity (existing other diseases).**

III.2. A **second opinion and a recommended treatment plan** drawn up based on the expert opinions of specialists (clinical oncologist, surgeon, radiation therapist) with substantial experience in treating the specific type of tumor.

III.3. **Assistance services – patient assistance during the examinations** with the involvement of a physician over the telephone
- regular in-depth advice given to the insured about necessary tests, procedures, and the related preparation
- answering client questions over the telephone about the examinations between 8am and 20pm on workdays
- scheduling examinations to allow for the optimal pace of diagnostics tests
- arranging consultations with specialists, as required.

III.4. **Opportunity for one-on-one consultations** with a surgeon, clinical oncologist, or radiation therapist specialized in the specific type of tumor
- for a maximum of 60 minutes each
- so that the insured person may ask questions and receive detailed information about his/her condition and the possible treatments available.

The insurance company's contracted health care service provider partner will contact the insured by phone or in an email within 5 workdays following the notification of the insurance claim.

If the insurance claim is not grounded for any reason, the insurance company may refuse to provide the service.

IV. OTHER RULES GOVERNING THE INSURANCE PAYOUT

IV.1. **If the results of the tumor diagnostic tests confirm the diagnosis of a malignant tumor, this cover of the insurance policy will terminate as of the next insurance anniversary following the date when the medical opinion and treatment plan has been handed over. No benefit may be claimed on the insurance policy between the date when the medical opinion and treatment plan are handed over and the subsequent policy renewal date (insurance anniversary).**

IV.2. **If the results of the tumor diagnostic service confirm benign tumors on two occasions, this cover of the insurance policy will terminate as of the next insurance anniversary following the date when the medical opinion and treatment plan related to the second benign tumor has been handed over. No benefit may be claimed on the insurance policy between the date when the medical opinion and treatment plan are handed over and the subsequent policy renewal date (insurance anniversary).**

IV.3. **For the purposes of these policy conditions, the handover date of the medical opinion and treatment plan shall be the date when the treatment plan is handed over.**

IV.4. The medical service provider delivering the tumor diagnostics service shall be entitled to assess if the service is covered under this insurance on the basis of the medical documentation of the insured.

IV.5. The provider of the Tumor Diagnostics service shall determine what tests to run based on the insured person's medical condition.
- The service – diagnostic testing – will be commenced as soon as the insured's condition so allows, and the insured patient attends the first medical consultation scheduled by the medical service provider with the insured and presents the test result(s) underlying the suspected malignancy.
- The necessary examinations can only be carried out if the insured person cooperates fully/attends the examinations punctually and consents to the examinations and the examination process. If the insured's cooperation is necessary for proceeding with the examinations (e.g.: request for the disclosure of tumor biopsy results), and the insured does not fully or properly cooperate, the diagnostic procedure will be halted until the necessary cooperation is obtained.
- If the insured condition requires hospitalization or emergency medical attention, the service offered under the insurance shall be delivered in the period following the duration of the hospitalization or emergency medical treatment.
- If the condition of the insured person does not allow the performance of a test or makes the assessment of the test result doubtful, the necessary tests will be performed at the time when the patient becomes fit to undergo the test.

IV.6. **This service may only be provided under one insurance policy even if the insured may be entitled to the covered service under multiple valid and effective insurance policies.**

IV.7. If the suspected malignancy is confirmed based on the findings revealed by this service, the insurance company will automatically start the claim settlement process under the 40 Critical Illnesses cover or the Malignant Tumor insurance cover taken out together with this cover and will pay out the insurance benefit if possible pursuant to the applicable policy conditions.

V. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

V.1. **In addition to the documents listed in Clause V.3.2 of the General Conditions applicable to the insurance policy, the insurance company may request or obtain the following documents if they are necessary to establish the legal basis and/or the amount of the claim notified:**

V.1.1. a **duly completed standard insurance claim form** made available by the insurance company,

V.1.2. **and a copy of the following documents:**
a) all medical documents produced in relation to the illness or complaint underlying the insured event;
b) **a document from a specialist or general practitioner describing the suspected malignant tumor;**
c) a report of a specific diagnostic test **supporting the suspicion of malignant neoplasm,** a medical document describing the complaint for which the test is intended, or the opinion of the competent specialist in the case of an elevated tumor marker level as a diagnostic test specific for cancer, or in the case of dermatology conditions, the recommendation of the dermatology specialist for additional testing.

V.2. **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 based on the findings of such review.**

V.3. **The insurance company may stipulate that a medical examination is required for the payment of the claim, and in such a case, the claim shall not be payable until the insured allows for the medical examination to be carried out.**

V.4. **If the insurance company is no longer able to deliver the medical management services specified in these special conditions for unforeseen reasons beyond its control, the contractual provisions governing the risks defined in these special conditions shall be terminated.**

VI. CESSATION OF CANCER DIAGNOSTICS SERVICES

The risk covered under these special conditions shall cease due to the impossibility of providing the service in the event of termination of the contract between the insurance company and the contracted partner providing the cancer diagnostic medical service for any reason. The insurance company shall inform the policyholder of the termination of the service 60 days before the termination takes effect.

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

In the case of this insurance policy, the insurance does not pay out the tumor diagnostics 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 Partial Disability Insurance to an extent exceeding 69% (EEOEP022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

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

I. INSURED PERSON

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

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

II. INSURED EVENT

II.1. The insured event is a **sudden, unexpected onset of an illness** without precedent conditions prior to the commencement of the insurance coverage, or **an accident** during the coverage period, **as theresult of which the Hungarian Institute of Medical Forensics determines in its expert's opinion that the insured has permanent partial disability to an extent exceeding 69%,** provided that the **insured submits the application for the determination of the permanent partial disability while the coverage is in force.**

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

III. INSURANCE BENEFIT

III.1. If an insured event occurs, the insurance company shall pay the **sum insured stated in the certificate of coverage effective as of the date of** the expert opinion of the National Board of Medical Experts – **or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter,** and at the same time the insurance cover subject to these special conditions shall terminate.

III.2. The **insurance company will refund** to the policyholder the **insurance premiums paid up on the insurance** taken out pursuant to these special conditions if the insured becomes ill **before the end of the waiting period** (Clause II.3 of the general conditions) with a disease that is **not in any way related to an accident,** which forms a basis for the **determination of a disability** of a degree exceeding 69%.

Once the premium is refunded, the part of the insurance policy offering the insurance coverage governed by these special conditions shall **terminate retroactively** to the inception date of such insurance cover.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. The claim must be notified to the insurance company **within 15 days** of receipt of the expert opinion of the National Institute of Medical Experts.

IV.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) **Expert opinion of the National Institute of Medical Experts;**
b) if the expert opinion of the National Institute of Medical Experts is issued after the termination of the insurance, a **document evidencing the date when the application** for the determination of the insured's disability of a degree exceeding 69% **was submitted;**
c) a statement by the treating physician or the general practitioner specifying the primary medical cause(s) of insured event, as well as the exact date of the first diagnosis and the progression of such disease(s),
d) additionally, if the insured's disability of an extent exceeding 69% is the result of an **accident:**
   – all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
   – the accident & injury report, or the workplace accident & injury report if one was made,
   – the blood alcohol and/or intoxicant test results, if one was administered;
e) **in the case of a road traffic accident,** in addition to the above:
   – a copy of the police report, if one was prepared,
   – if the insured **was injured** in a road traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.

IV.4. **For the payment of the insurance benefit, the insurance company may require that the following documents also be submitted:**
– an official certificate of the insured person's date of birth.

IV.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 based on the findings of such review.**

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

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

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

VI. TERMINATION OF THE INSURANCE UNDER THESE SPECIAL CONDITIONS

The part of the insurance policy offering the insurance coverage governed by these special conditions shall terminate if any one of the following conditions occurs:

a) after the insurance company's **payout of insurance benefits** specified in these special conditions, or
b) if the insured becomes **eligible for old-age state pension,** or
c) if the insured reaches the **retirement age applicable to him/her.**

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

Special Conditions of Partial Disability Insurance to an extent exceeding 39% (EEOEP122)

These special conditions set out the standard terms and conditions for the **disability to an extent exceeding 39% cover** of insurance policies offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policies.

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

I. INSURED PERSON

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

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

II. INSURED EVENT

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

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

III. INSURANCE BENEFIT

III.1. If an insured event occurs, the insurance company shall pay the **sum insured stated in the certificate of coverage effective as of the date of** the expert opinion of the National Board of Medical Experts – **or if the insurance policy was already terminated, in the last effective certificate of coverage – or in the indexation offer letter,** and at the same time the insurance cover subject to these special conditions shall terminate.

III.2. The **insurance company will refund** to the policyholder the **insurance premiums paid up on the insurance** taken out pursuant to these special conditions if the insured becomes ill **before the end of the waiting period** (Clause II.3 of the general conditions) with a disease that is **not in any way related to an accident,** which forms a basis for the **determination of a disability** of a degree exceeding 39%.

Once the premium is refunded, the part of the insurance policy offering the insurance coverage governed by these special conditions shall **terminate retroactively** to the inception date of such insurance cover.

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

IV.1. The claim must be notified to the insurance company **within 15 days** of receipt of the expert opinion of the National Institute of Medical Experts.

IV.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) **the expert opinion of the National Institute of Medical Experts;**
b) in the case of a medical opinion issued by the National Institute of Medical Experts after the termination of the insurance, **proof of the date of the application for the determination** of the disability of an extent exceeding 39%;
c) **a statement from the treating physician or the general practitioner describing the underlying medical cause(s) of the insured event, as well as the exact date of the first diagnosis;**
d) additionally, if the insured's disability of an extent exceeding 39% is the result of an accident:
   – all medical documents produced in connection with the insured event **from the occurrence of the accident until the notification of the insurance claim,**
   – the accident & injury report, or the workplace accident & injury report if one was made,
   – the blood alcohol and/or intoxicant test results, if one was administered;

e) **in the case of a road traffic accident,** in addition to the above:
   – a copy of the police report, if one was prepared,
   – if the insured **was injured** in a road traffic accident as **the driver of a motor vehicle,** his/her driving license and the vehicle registration certificate.

IV.4. **For the payment of the insurance benefit, the insurance company may require that the following documents also be submitted:**
– an official certificate of the insured person's date of birth.

IV.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 based on the findings of such review.**

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

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

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

VI. TERMINATION OF THE INSURANCE UNDER THESE SPECIAL CONDITIONS

The part of the insurance policy offering the insurance cover governed by these special conditions shall terminate if any of the following conditions occur:

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

If any one of the conditions listed in subsections b) and c) of this chapter occur, **the policyholder must notify the insurance company in writing within 15 days of the occurrence of the condition.**

Special Conditions of Incapacity Insurance (EEKEK022)

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

In the case of matters **not regulated by these special conditions,** the insurance shall be **governed by the General Terms and Conditions of TestŐr Term Life, Accident and Health Insurance** (TÁSZF022) (hereinafter referred to as the General Conditions) of Generali Biztosító Zrt, by reference to which the insurance policy has been concluded. In other matters, the provisions of the **Hungarian Civil Code** and other **effective Hungarian legal acts** shall apply mutatis mutandis to the policy.

I. INSURED PERSON

I.1.a) A **natural person who** is **not entitled to statutory sick pay** under the compulsory health insurance scheme in his/her own right **cannot be insured** under these special conditions.

b) Before accepting the insurance application, the insurance company may request written proof that the insured is entitled to statutory sick pay under the compulsory health insurance scheme, i.e. it may request proof that the insured pays the cash sickness insurance contribution specified in Act LXXX of 1997.

I.2. The **insured must** notify the insurance company in writing **within 15 days**

a) after the occurrence, if his/her **entitlement to the statutory sick pay** under the compulsory health insurance scheme ceases **during the term of the policy** subject to these special conditions.
In this case, the incapacity insurance cover of the insurance policy will terminate on the first day of the month following the month in which the entitlement to the statutory sick pay ceases.

b) upon receipt of the resolution of the National Pension Insurance Administration, **if he/she becomes entitled to old-age pension, disability, accidental disability or rehabilitation allowance or other pension-like benefits (hereinafter collectively referred to as 'pension') during the term of the policy.** In such a case the incapacity insurance coverage of the insurance shall terminate on the first day of the month following the date when the insured becomes eligible for pension.

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

II. INSURED EVENT

II.1. The insured event is the insured's sudden **illness** which is unprecedented relative to the commencement of the insurance coverage or **an accident** (Clause IX.1 and Clause IX.3) which occurs during the coverage period, as a result of which the Insured becomes continuously incapacitated (temporarily disabled) in his/her own right, and is granted a statutory sick pay in accordance with effective legislation, and the insured's incapacity is certified by an approved physician who is authorized to assess and certify the incapacity status.

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

III. INSURANCE BENEFIT

III.1. **If an insured event occurs, the insurance covers the days of the insured's incapacity due to illness during the coverage period, and the days of the insured's incapacity due to an accident within two years after the date of the accident.**

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

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

III.4. If the **insured person becomes incapacitated due to an accident after the termination of this insurance policy but within two years of the date of the accident** during the coverage period, the amount of the benefit payable under this cover will be determined **based on the sum insured stated in respect of this cover in the last certificate of coverage or in the last indexation offer letter.**

III.5. If the insurance renewal date falls within a period when the insured is certifiably incapacitated within the meaning set out herein, and the **insurance policy is taken out with annual indexation** (Clause IV.4. of the general conditions), the insurance company shall pay to the insured an increased benefit in accordance with the rules of annual indexation, after the renewal date.

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

IV. PAYMENT OF CLAIMS – PAYMENT CONDITIONS

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

IV.2. Where the **above time limit is not respected,** and as a result material conditions or circumstances cannot be revealed, **the insurance company shall be exempt from the payment of the insurance benefit.**

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

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

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

a) a standard form issued by a physician authorized to certify incapacity for work, in accordance with the legislation in force (Medical certificate of incapacity for work (pregnancy));
b) if the insured was hospitalized: the hospital discharge summary, within 15 days after the end of the hospital treatment;
c) additionally, if the insured event is the result of an **accident:**
   – all medical documents produced in connection with the insured event from its occurrence until the notification of the insurance claim,
   – the accident & injury report, or the workplace accident & injury report if one was made,
   – the result of the blood alcohol and/or drug test, if one was 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 **was injured** in a traffic accident as **the driver of a vehicle,** a copy of the insured's driving license and the vehicle registration certificate.

IV.4. **In any continuing period of incapacity:**

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

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

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

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

V.1. In the case of this insurance policy, the insurance does not pay out the incapacity 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.

V.2. In addition to the exclusions set out in the general conditions, the insurance company shall not be liable for the insured's incapacity for work during which the insured pursues earning activities.