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OUDZO
IX/2016

The Executive Board of UNIQA neživotno osiguranje a.d.o, Belgrade, 134g Milutin Milanković Street (hereinafter referred to as: the Company), according to the Companies Act ("Official Gazette of the RS", no. 36/11, 99/11, 83/14-as amended, 5/2015), and Article 10 of the consolidated text of Articles of Association 01/NŽ-SA/02 dated 01 March 2016, and based on the Decision dated 14 September 2016 enacted this document.

GENERAL TERMS AND CONDITIONS OF VOLUNTARY HEALTH INSURANCE

INTRODUCTORY PROVISIONS

Article 1

1) These General Terms and Conditions of Voluntary Health Insurance (hereinafter referred to as the General Terms and Conditions) constitute the integral part of the Agreement on Voluntary Health Insurance (hereinafter referred to as the Insurance Agreement) that the Policyholder voluntarily concludes with UNIQA neživotno osiguranje a.d.o. Beograd, as the Insurance Provider/ the Insurer.

2) The General Terms and Conditions govern the rights and obligations of the Policyholder, the Insured and the Insurer, depending on the type of concluded Agreement on Voluntary Health Insurance.

DEFINITIONS

Article 2

1) Certain terms used in these General Terms and Conditions have the following meaning:

- **Insurance Provider** (hereinafter referred to as the **Insurer**) – UNIQA neživotno osiguranje a.d.o. Beograd, that organizes and implements voluntary health insurance in accordance with law;
- **Insured** – is a physical entity who has concluded the Agreement on Voluntary Health Insurance or, on whose behalf, and with the consent of whom, the Agreement on Voluntary Health Insurance is concluded with the Insurer, and who uses the rights set forth in the Agreement on Voluntary Health Insurance, as well as a member of family and/or household of the Insured;
- **Voluntary Health Insurance Policyholder** (hereinafter referred to as the **Policyholder**) – is a legal or physical entity, as well as other legal entity that concludes the Agreement on Voluntary Health Insurance with the Insurer, and undertakes to pay insurance premium from its own funds or from the funds of the Insured.
- **Offering Party** – is a legal or physical entity that has an intention to conclude the Agreement on Voluntary Health Insurance and for this purpose submits an insurance proposal to the Insurer;
- **Proposal** – is a written proposal to conclude the Agreement on Voluntary Health Insurance submitted by the Offering Party to the Insurer;
- **Insurance Policy** – is a document on concluded Agreement on Voluntary Health Insurance entered into with the Insurer;
- **Document on Voluntary Health Insurance** – is a document issued to the Insured by the Insurer based on which the Insured proves its insured status under voluntary health insurance and exercises the rights under voluntary health insurance;
- **Insurance premium** – is the pecuniary amount payable to the Insurer by the Insured, i.e. the Policyholder of voluntary health insurance;
- **Sum insured** – is the pecuniary amount and/or medical services defined in the Policy representing the maximum liability of the Insurer according to the concluded Insurance Agreement;
- **Insured event** – implies a future uncertain event when due to an impairment in the health condition (a disease or injury) the Insured has undergone a medically justifiable treatment, which is a subject-matter of the insurance agreement and the costs of which need to be paid to a healthcare institution, private practice, or other provider of healthcare services or to the Insured person depending upon the contracted Policy;
- **Waiting period** – is the contracted time period at the beginning of the insurance period during which the Policyholder pays the Insurance Premium, and the Insurer is not liable to pay out insurance indemnity regardless of the fact that the insured event has occurred;
- **Pecuniary compensation** – is the indemnification provided to the Insured by the Insurer in case of lost earnings, i.e. salary or other income because of temporary incapacity to work, compensation for the costs of transportation related to the use of healthcare protection, as well as other types of pecuniary compensation related to the exercising of rights under voluntary health insurance;
- **Healthcare services** – are services provided in healthcare institutions and other forms of healthcare service (hereinafter referred to as the Private Practice), in accordance with the law governing healthcare protection, for the purpose of conducting healthcare protection, i.e. for the purpose of implementation of measures for protection and improvement of people's health, prevention, combat and early detection of diseases, injuries and other health impairments, for treatment and rehabilitation, including healthcare services from traditional medicine, which are safe, of good quality and efficient;
- **Healthcare institution** – is a legal entity conducting a healthcare activity, which has obtained a license from the Ministry in charge of healthcare affairs (hereinafter referred to as: the Ministry) to conduct healthcare activities in accordance with the law governing healthcare protection and regulations reached so as to implement such law;
- **Private practice** – is another form of healthcare service in which certain activities of the healthcare activity are conducted and which has obtained a license from the Ministry to conduct certain healthcare activities in accordance with the law governing healthcare protection and regulations reached so as to implement such law;
- **Other healthcare providers** – are other legal or physical entities that conduct certain healthcare activities, i.e. provide medical-technical aids, and which have obtained a license from the competent authority to conduct such activities, in accordance with law;
- **Medicine** – a product which has been approved to be put on the market of the Republic of Serbia, as well as a product that has not been approved to be put on the market of the Republic of Serbia and which is imported on the basis of the approval of the Agency for Medicines and Medical Devices of Serbia, in accordance with the law governing the area of medicines;
- **Medical-Technical Aids** – are medical devices used to functionally and esthetically replace missing body parts, or used to provide support, prevent deformities and correct the existing deformities, and to facilitate the performance of basic life functions;
- **Implant** – is a medical aid which is surgically implanted into a human body;
- **Special terms and conditions of voluntary health insurance** (hereinafter referred to as the **Special Terms and Conditions**) – are the terms and conditions of the Insurer that govern the rights and obligations of the Parties regarding a specific type of voluntary health insurance, and that constitute the integral part of the Agreement on Voluntary Health Insurance.
- **MedUNIQA Contact Centre** – is the call center of the Insurer through which medically educated persons are made available to the insured persons in order to provide the latter with the assistance when it comes to exercising the insurance in the manner set forth in the special terms and conditions.
- **Reimbursement** – is the right of the Insured to recover from the In-

surer, in line with the insurance agreement, i.e. Policy, treatment costs or part thereof incurred by exercising rights under the agreement.

- **Co-payment** – is a share in part of costs of certain, contracted, medically justifiable treatment the Insured is obliged to pay if so be agreed in the Policy, i.e. insurance agreement.

GENERAL PROVISIONS

Article 3

1) By the Insurance Agreement, the Policyholder undertakes to pay the premium to the Insurer, whereas the Insurer undertakes, should the insured event occur, to compensate for the treatment costs or pay out pecuniary compensation in accordance with these General Terms and Conditions, Special Terms and Conditions and the Agreement on Voluntary Health Insurance.

2) All the notices and notifications that the Parties are required to make must be confirmed in writing if made orally, over the phone or otherwise.

3) The date of receipt of the notice, i.e. notification referred to in paragraph 2) of this Article, shall be deemed the date when the Insurer has received the notice or notification, or the date indicated in the Insurer's registry.

4) The Parties hereby agree to submit all the notices by registered mail at the address specified in the proposal, i.e. at another address if the other Party has been duly informed about it. A notice dully made by the Policyholder / the Insured to the Insurer on the change of address must be made by means of a registered mail. A notice dully made by the Insurer to the Policyholder / the Insured on the change of address must be made by mail or a notice published by means of public information. In case of a failed registered mail delivery, it shall be regarded that such delivery has been made and it shall produce legal effect between the Parties.

5) Agreements that are related to the contents of the Agreement on Voluntary Health Insurance shall be valid only if concluded in writing.

6) Every conversation of the Insured with medically educated staff from MedUNIQA Call Centre is recorded.

TYPES OF VOLUNATRY HEALTH INSURANCE

Article 4

1) Voluntary Health Insurance covers the costs for the type, contents, scope and standard of the rights that are contracted with the Insurer, i.e. provides pecuniary compensation as provided for in the Insurance Agreement.

2) Types of voluntary health insurance are:

a) Parallel health insurance is the insurance that covers the costs of healthcare protection incurred when the Insured uses the healthcare protection that is covered under the mandatory healthcare insurance in the manner and in accordance with the procedure other than the manner and procedure of exercising the rights under the mandatory healthcare insurance that is set forth by the law governing health insurance and regulations reached to implement such law;

b) Supplemental health insurance is the insurance that covers the costs of healthcare services, medicines, medical-technical aids and implants, i.e. pecuniary compensation that is not covered by rights under the mandatory health insurance, i.e. insurance for a greater contents, scope and standard of rights, as well as the amount of pecuniary compensation covered by the mandatory health insurance;

c) Private health insurance is the insurance of persons who are not covered by the mandatory health insurance or who are not included into the mandatory health insurance, to cover the costs of the type, contents, scope and standard of the rights that are contracted with the Insurer;

3) The Insurer shall organize and conduct a combination of voluntary health insurance lines from paragraph 2) hereof.

GAINING THE STATUS OF THE INSURED

Article 5

1) The status of Insured under parallel, or supplemental voluntary health insurance may be gained by a person who has obtained the insured status under the mandatory health insurance in the Republic of Serbia, and who has expressed a clear intention to conclude with the Insurer the Agreement on parallel or supplemental voluntary health insurance.

2) The status of the Insured under private voluntary health insurance may be gained by a person who is not insured within the meaning of the mandatory health insurance, and who has expressed a clear intention to conclude with the Insurer the Agreement on private voluntary health insurance.

3) The status of the Insured may also be gained by family and/or household members of the Insured in accordance with the Special Terms and Conditions of the Insurer.

CONCLUDING THE INSURANCE AGREEMENT

PROPOSAL

Article 6

1) The Proposal makes the integral part of the Insurance Agreement.

2) The Insurance Agreement is concluded on the basis of a written proposal submitted by the Offering Party on the Insurer's form.

3) In case the Agreement on Collective Insurance is to be concluded, the Policyholder may submit a unified proposal which contains data on each individual person who all want to be insured with the Insurer. If the Policyholder and the Insured are not one and the same entity, to conclude voluntary health insurance it is necessary to submit written consent of the Insured, except in case of Collective Insurance. Should the Insured be a minor, the insurance agreement is to be signed by his/her parent or guardian.

4) When concluding the Insurance Agreement, the Policyholder, i.e. the Insured, is obliged to disclose to the Insurer all the circumstances that are significant for the risk assessment, which are known to him/her or could not have remained unknown. When contracting, the Insured is obliged, at the Insurer's request, to sign that he/she agrees with the Statement on health condition provided that he/she entirely agrees with the same, i.e. agrees to fill in the Questionnaire on health condition (hereinafter referred to as the Questionnaire), which constitute the integral part of the Proposal, and to submit other documentation required to assess the risk, except in case of contracting for collective insurance in which case the Questionnaire is not mandatory.

5) The data from the Questionnaire may not constitute the reason for refusing voluntary health insurance acceptance.

6) In the Proposal, all the data relevant and necessary to conclude the Insurance Agreement must be stated accurately, truly and completely, as well as the circumstances relevant for underwriting risk.

7) A written Proposal submitted to the Insurer to conclude the Insurance Agreement binds the Offering Party, unless it has specified a shorter period, for the period of 8 days from the date on which the Proposal is received by the Insurer, and in case a health evaluation is required then for the period of 30 days.

8) The Proposal is deemed received by the Insurer on the date when it is officially registered by the Insurer. In case the Insurer, after having received the Policyholder's proposal, should require any additional data or documentation, the Insurer shall be deemed to have received the Proposal on the date when it received such requested data, i.e. reports on completed medical examinations.

9) If the Insurer fails to offer, within 8 days, i.e. within 30 days in case a medical evaluation is required from the date on which the Proposal is received by the Insurer, the insurance with modified terms and conditions, it shall be regarded that it has accepted the proposal and that the Agreement is concluded on the date when the Proposal is received by the Insurer.

10) Should the Insurer accept the insurance proposal only under modified terms and conditions, the insurance shall be regarded concluded on the date when the Offering Party agrees to the modified terms and conditions.

11) The Offering Party is deemed to have abandoned the Proposal if it does not accept the modified terms and conditions within 8 days from the date of receiving the Insurer's registered notice sent by mail or electronic mail (by means of e-mail), i.e. if in case of individual health insurance it does not submit results of the completed medical examination within 30 days from the date of receiving the written request of the Insurer to complete a medical examination.

12) If within the period between submitting the Proposal and concluding the Insurance Agreement there should be an increase in the risk to health of the insured persons regarding individual health insurance, the Insured, i.e. the Offering Party, is obliged to immediately upon gaining knowledge of such circumstances notify the Insurer thereof. The increased risk to health of the insured in case of individual health insurance, within the meaning of this paragraph, means any disease, i.e. illness, a change of profession, injuries of the insured, practicing sports or travelling to high-risk areas, tropical

areas or expeditions, as well as other changes that increase a risk to the health of the insured.

13) The Insurer may propose amendments to insurance terms and conditions after having entered into the Agreement if the Insured at the moment of concluding this Agreement was suffering from diseases that he/she failed to report when submitting the Proposal.

14) The Insurer may establish that the Insured was suffering from a certain disease which he/she failed to report when submitting the Proposal in one of the following manners:

a) Upon conducting a general health examination or some other examination, i.e. when using the services covered by the Agreement on individual insurance;
b) From the communication with MedUNIQA Contact Centre and medical reports delivered subsequently.
   1. If the Offering Party does not agree to the amended terms and conditions in case defined in paragraph 13) hereof, i.e. to the proposal of amended insurance terms and conditions of the Insurer within 8 days from the date of receiving the notice, the Agreement shall be deemed terminated upon expiry of such period.
   2. In case of termination of the Agreement referred to in Paragraph 15), Point 1 of this Article, the Insurer is entitled to the entire amount of premium due, except when an insured event occurs up to the date of termination, in which case the Policyholder is obliged to pay to the Insurer the entire premium for the current insurance year upon the termination of the Insurance Agreement, notwithstanding the payment terms agreed.
   3. By signing the Proposal, i.e. Policy, the Insured, i.e. Policyholder, confirms that he/she accepts the General and Special terms and conditions.

INSURANCE POLICY

Article 7

1) Based on the data provided in the proposal, the Insurer issues the Insurance Policy on the date of signing the Insurance Agreement.

2) In Collective Insurance Agreements, the Insurer issues one Insurance Policy which covers all the persons that are included in the list of the Insured, which constitutes integral part of the Insurance Agreement, i.e. Insurance Policy.

3) In cases when the Insurance Agreement is also concluded for family and/or household members of the Insured, the Insurer may issue one Insurance Policy which covers the insurance holder and his/her family and/or household members who are insured.

DOCUMENT ON VOLUNTARY HEALTH INSURANCE

Article 8

1) On the basis of the Insurance Policy, the Insurer is bound to issue to each Insured person, on the day of issuance of the Policy, but not later than within 60 days, a Document on voluntary health insurance (hereinafter referred to as: the Document).

2) By means of the Document, the Insured proves his/her insured status and may exercise the rights under the voluntary health insurance.

3) The Document is issued for the term of the insurance.

4) Until the moment of issuing the Document, the rights under the voluntary health insurance may be exercised on the basis of the Insurance Policy.

5) The Document is valid when accompanied by a personal ID document.

6) The Insured is bound to immediately notify the Insurer in writing in case of a lost, stolen or damaged Document. In such case, the Insurer shall issue a copy of the Document.

INSURED RISKS

Article 9

1) An insured event represents a future uncertain event when due to an impairment in the health condition (a disease or injury) the Insured has undergone a medically justifiable treatment (healthcare services, medicines, medical-technical aids, implants, etc.), which is a subject-matter of the insurance agreement and the costs of which need to be paid to a healthcare institution, private practice, or other provider of healthcare services or to the Insured person depending upon the contracted insurance coverage defined in the Policy.

2) In case of the insured event occurrence, within the meaning of these Terms and Conditions, the Insurer is bound to compensate for standard and usual costs, which are incurred during the term of the Insurance Agreement, up to the contracted amount of coverage.

3) The insured event commences with the beginning of a medically justifiable treatment, therapy, and ends at the moment when, from a medical perspective, the need for the therapy no longer exists.

TERM OF THE INSURANCE AGREEMENT

Article 10

1) The Insurance Agreement can be concluded for an indefinite or definite term, for at least 12 (twelve) months, except in cases:
   1. When the insured status under mandatory health insurance lasts for a shorter period of time in accordance with the regulations that govern mandatory and voluntary health insurance, whereby the Policyholder is bound to notify the Insurer when the Insured's status of the Insured under mandatory health insurance ceases;
   2. Of contracting private voluntary health insurance.

2) The Insurance Agreement may be contracted with the following terms:
   1. Short-term:
      a) Equal to ("=") 12 (twelve) months in cases of parallel and supplemental voluntary health insurance;
      b) Less than or equal to ("≤") 12 (twelve) months in case of private voluntary health insurance;
   2. Long-term – for an indefinite term;
   3. Multi-year – for a definite term.

3) In cases of long-term and multi-year Insurance Agreements, before the insurance year expires the Insurer shall provide a calculation policy for the following insurance year.

4) When contracting the insurance for indefinite and multi-year definite terms, the Policyholder may be approved a discount on the insurance premium according to the Tariff.

5) In case of contracting the discount referred to in the previous paragraph hereof, the Policyholder is deemed obliged to maintain the Insurance Agreement effective for at least 2 (two) years.

6) The insurance begins at the expiry of 24.00th hour of the date specified in the Policy as the insurance inception date, but not before the expiry of 24.00th hour of the date when the premium, i.e. a premium installment, is paid.

7) The insurance expires at the expiry of 24.00th hour of the date specified in the Policy as the insurance expiry date.

8) The insurance shall cease even before the expiry of the contracted period in case of the following:

1. Death of the Insured – as of the date of death;
2. Exclusion of an Insured person from the insurance by the Policyholder in case of collective insurance – on the date when the request is submitted to the Insurer and only if such right is specified in the Special Terms and Conditions of the Insurer and if contracted in the policy;
3. Termination of the Agreement in accordance with Article 17 of these General Terms and Conditions;
4. Cancellation of the Agreement – upon the expiry of the notice period, in accordance with Article 17 of these General Terms and Conditions; in case of parallel and supplemental insurance, i.e. a combination of parallel and supplemental health insurance, as of losing the status of the Insured under mandatory health insurance – on the date of losing such status;
5. In case of private health insurance, upon gaining the status of the Insured under mandatory health insurance - on the date of gaining such status.

WAITING PERIOD

Article 11

1) A waiting period is the period during which the Insurer is not obliged to pay out any indemnification under the insurance should an insured event occur.

2) The waiting period begins from the insurance inception date defined in the policy provided that the first agreed premium has been paid by that day.

3) In case that the first agreed premium is not paid by the insurance inception date, the waiting period begins from the expiry of 24.00th hour of the date when the first contracted premium is paid.

4) The waiting period is not applicable when the Agreement is renewed with the same Insurer, unless specified otherwise in the Insurance Agreement.

PREMIUM AND CONSEQUENCES OF FAILING TO PAY THE PREMIUM

Article 12

1) The amount and method of premium payment are specified in the Insurance Agreement, i.e. Insurance Policy.

2) The premium amount is determined by the Insurer in accordance with the premium tariff and regulations governing the area of voluntary health insurance.

3) The Policyholder, i.e. the Insured, is bound to regularly pay the premium to the Insurer, on the due date, within deadlines specified in the Insurance Agreement, i.e. Insurance Policy.

4) If the annual premium is contracted to be payable in semi-annual, quarterly or monthly installments, the Insurer is entitled to receive the premium for the entire year of insurance term.

5) Exceptionally from paragraph (4) of this Article, in case of termination of the insurance as the result of the Insured's death, the Insurer is entitled to receive the premium up to the date of death of the Insured.

6) The Insurer is entitled to charge the Policyholder for legal default interest for each day of exceeding the deadline by which it was bound to pay the insurance premium due.

7) The first contracted Insurance Premium, i.e. the first premium installment, falls due on the inception date of the Insurance Agreement.

8) Each subsequent premium installment falls due on the last day of the current time period for the insurance premium payment (semi-annually, quarterly or monthly) for the following time period.

9) The premium is deemed paid on the date when the same is posted in the Insurer's account.

10) The Insurer is also obliged to accept the premium payment made by any person who has a legal interest in ensuring that the premium is paid.

11) The Insurer may not increase the premium during the term of the Agreement concluded (regardless of the duration of Agreement), except in cases set forth in paragraphs 13 and 14 of Article 6.

12) Exceptionally from paragraph 11) of this Article, in case of Agreements concluded for a period of several years, the premium may be changed after expiry of a 12-month period from the date of concluding the Insurance Agreement, i.e. every 12 months until expiry of the term of the Insurance Agreement concluded.

13) If the Policyholder fails to pay the contracted premium that has fallen due, i.e. premium installment, the liability of the Insurer to cover costs, i.e. part of costs for the medical services provided that are covered under the Insurance Agreement, i.e. Insurance Policy, shall cease upon expiry of the period of 30 days from the date when the Policyholder receives a written notice on overdue and unsettled premiums.

14) Upon expiry of the period referred to in paragraph 13) of this Article, the Insurer may terminate the Insurance Agreement without any subsequent notice period and initiate the procedure before a competent court to collect the overdue premium with accrued interest.

OBLIGATIONS OF THE INSURER

Article 13

1) The Insurer is bound to enable the Insured to exercise his/her rights provided for under the Agreement on voluntary health insurance, as well as the rights defined under these General Terms and Conditions, Special Terms and Conditions and the Insurance Agreement.

2) The Sum Insured specified in the Policy represents the upper limit of the Insurer's obligation under the Insurance Agreement.

3) In line with the Insurance Agreement, i.e. Policy, these General Terms and Conditions and Special Terms and Conditions, the Insurer is obliged to compensate a healthcare service provider or the Insured for treatment costs or part thereof incurred due to exercising the rights under the agreed line of voluntary health insurance, as well as the agreed amount of pecuniary compensation within 14 days as of the date when it received complete documentation based on which the indisputable existence and scope of obligation can be established.

4) If the right under the insurance has been agreed to be exercised through reimbursement, the Insurer is obliged, in accordance with the Insurance Agreement, i.e. Policy, to reimburse for the costs of treatment or part thereof that arise from exercising the rights under the agreed line of voluntary health insurance, as well as the amount of the agreed pecuniary compensation within 14 days as of the date when it received complete documentation based on which the indisputable existence and scope of obligation can be established.

5) The Insurer is entitled to request from the Insured, Policyholder or any other legal or physical entity to provide additional explanations or additional documentation in order to establish important circumstances relevant for the reported Insured Event.

6) The Insurer is entitled to refer the Insured to a control medical examination or additional medical examination, by which necessary circumstances relevant for the reported Insured Event would be established. The costs of such evaluations are borne by the Insurer.

7) The Insurer hereby undertakes not to, at the moment of concluding the Insurance Agreement, request any genetic data, i.e. results of genetic tests for the Insured, as well as for their next of kin, regardless of the line and degree of kinship.

EXCLUSIONS OF THE INSURER'S OBLIGATION

Article 14

1) The Insurer's obligation is excluded in case of the following:

1. If the Insured provides incorrect and false data, i.e. withholds important circumstances that have influence on concluding the Insurance Agreement;
2. If the Policyholder, i.e. the Insured, fails to pay due premium by the contracted deadline, and the premium is not paid on his/her behalf by any other person who has a legal interest in ensuring that the premium is paid;
3. In case of abusing the policy, i.e. Document;
4. If the scope of contracted medical services and the amount of costs has been exceeded;
5. If a claim is based on false data and false documentation;
6. If the Insured Event has occurred and is lasting at the moment of concluding the Agreement, i.e., in case of costs of treating a disease of the Insured that he/she is suffering from at the time of concluding the Insurance Agreement, unless otherwise agreed;
7. If the Insured Event occurs during the period of insurance, and the treatment of the Insured continues past the expiry date of Insurance Agreement, the Insurer is obliged to compensate for the costs of healthcare protection, i.e. to pay out the contracted indemnification, incurred by the expiry date of the Insurance Agreement, except in case when the Insurance Agreement is renewed;
8. If the subject-matter of insurance claim are costs of arranging and administering preventive programs of vaccination, immunoprophylaxis and chemoprophylaxis, which are compulsory under the Republic program on immunization of citizens against certain types of contagious diseases;
9. For the compensation for costs of healthcare protection and payment of indemnification covered under the mandatory health insurance for the very identical type, contents, scope, standard, manner and procedure of exercising rights under the mandatory health insurance set forth by law, except in case of private health insurance.

RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED

Article 15

1) The Insured may exercise his/her rights under the Insurance Agreement on the basis of the document on insurance (or policy), which he/she must present to the healthcare institution, private practice or another provider of healthcare services.

2) The rights under the Insurance Agreement may not be transferred or assigned to third parties.

3) Pecuniary compensation that has fallen due for payment but have not been paid out for the death of the Insured may be inherited in accordance with provisions of law.

4) In case the Policyholder and the Insured are not one and the same entity, the Policyholder is obliged to fully acquaint the Insured with terms and conditions of insurance, i.e. to inform him/her on the rights to receive indemnity that arise from the contracted line of voluntary health insurance.

5) The Policyholder i.e. the Insured is obliged to submit all the documentation to the Insurer necessary to establish the existence of grounds, scope

and extent of Insurer's liability.

6) The Policyholder, i.e. the Insured, is obliged to notify the Insurer as soon as practicable of any data change regarding insured persons, such as change of residential address, change of last name, occupation, marital status, termination of employment, change of status regarding mandatory health insurance, number of insured persons, etc.

7) The Policyholder is bound to ensure that all persons insured in line with these General terms and conditions are acquainted with the contents thereof.

COMMENCEMENT AND EXPIRY OF THE INSURER'S OBLIGATION

Article 16

1) The Insurer's obligation begins upon expiry of 24.00th hour of the date specified in the Policy as the insurance inception date, but not before expiry of 24.00th hour of the date when premium, i.e. the first premium installment is paid, unless otherwise agreed.

2) In case the waiting period is agreed, the Insurer's obligation begins upon expiry of 24.00th hour of the waiting period expiry date, provided that the premium, i.e. the first premium installment is paid.

3) The Insurer's liability ends upon expiry of 24.00th hour of the date that is specified in the Policy as the insurance expiry date.

4) Exceptionally from paragraph 3) of this Article, the Insurer's liability ends in the manner set forth in Article 12 of these Terms and Conditions.

TERMINATION AND CANCELLATION OF THE INSURANCE AGREEMENT

Article 17

1) In case the Policyholder or the Insured made a false claim or withheld a circumstance that was of such nature that the Insurer would not have concluded the Agreement under the same terms and conditions had it known about the actual state of affairs, the Insurer may request termination of the Agreement.

2) The Insurer may unilaterally terminate the Agreement in accordance with Article 12, Paragraph 14) of these Terms and Conditions.

3) Either Party may cancel the Insurance Agreement, unless it has ceased to apply for another reason.

4) The Insurance Agreement may be terminated by either party by informing the other party in writing thereof not later than three months prior to expiry of the current insurance year.

5) Should the Policyholder acknowledge that it terminates the agreement prior to the expiry of the term defined in Paragraph 5) of Article 10 under these terms and conditions, it is obliged to refund the Insurer the amount of discounts granted on insurance premiums in previous years.

6) The refund of granted discounts referred to in the previous paragraph the Insurer calculates by multiplying the granted discount for the current insurance year in which the agreement is terminated by the number of years passed from the insurance inception, depending on the year in which the insurance agreement is terminated.

7) In case of paying the premium in installments, the refund of discount in the current year of termination is calculated by principle "pro rata temporis" (the premium calculation is performed based on the number of insurance days).

8) The Insured is obliged to refund the granted discount within 5 (five) days from the date of receiving the calculation of total granted discounts to be refunded.

9) In case of unilateral termination of Insurance Agreement by the Policyholder prior to expiry of the term for which the Insurance Agreement is concluded, the Insurer is obliged to refund the Policyholder the insurance premium for the unused period of insurance.

10) The calculation of the insurance premium to be refunded is performed by principle "pro rata temporis" and is made only if the premium referring to the future period has been paid.

11) If an insured event occurs by the date of termination, the Policyholder is obliged to pay to the Insurer the entire premium for the current insurance year upon the termination of the Insurance Agreement, notwithstanding the payment terms agreed.

COMPLAINT OF THE INSURED

Article 18

1) The Insured who believes that the decision (resolution) of the Insurer on an insurance claim violated his/her rights under the Insurance Agreement may lodge a complaint to the Insurer's Complaints Committee within 30 days from the date of receiving the decision (resolution) of the Insurer.

2) The Complaints Committee of the Insurer is bound to make a decision on the complaint and notify the Insured thereof within 30 days from the date of receiving the complaint of the Insured.

DATA ON THE INSURED

Article 19

1) By signing the proposal and Insurance Policy, the Policyholder and the Insured authorize the Insurer to collect, verify, process, store, transfer and use personal data required to conclude the Insurance Agreement in accordance with the law governing personal data protection.

2) The Insurer undertakes to keep the data referred to in paragraph 1) of this Article as a business secret, in accordance with law.

THE RIGHTS OF RECOURSE

Article 20

1) The rights of the Policyholder or the Insured against a third party are transferred to the Insurer, in the amount of the liability paid out by the Insurer, without the need to obtain any special consent of the Insured person.

2) In order to exercise the right of recourse within the meaning of paragraph 1) of this Article, the Insured is obliged to provide to the Insurer all the evidence that the Insurer may request from it, referring to the insurance claim. The costs of obtaining such evidence are borne by the Insurer.

3) If the Policyholder or the Insured receives any indemnity from the third party held responsible for the damage, the Insurer is entitled to deduct such amount from the indemnity that is to be paid out to the Insured based on the Insurance Policy.

TRANSITIONAL AND FINAL PROVISIONS

Article 21

1) These General Terms and Conditions may be amended following the procedure and manner in which they are adopted.

2) The amended Terms and Conditions apply only to newly-contracted insurance agreements, i.e. insurance policies.

3) Regarding existing insurance agreements, the General Terms and Conditions based on which such agreements are concluded shall apply until expiry of the insurance year, unless the terms and conditions are changed as a result of changes in legal regulations, which is beyond control of the Insurer.

4) Should the Insurer amend the General Terms and Conditions of Insurance, it is obliged to make a written notification thereof to the Policyholder, i.e. the Insured, with whom it has concluded a multi-year Insurance Agreement.

5) The Insurer undertakes to publish the latest version of these General Terms and Conditions on its website.

Article 22

1) Any claims under the Insurance Agreement are subject to the statute of limitations pursuant to the Law of Contracts and Torts.

Article 23.

1) All the relations between the Parties that are not governed by these General Terms and Conditions are subject to provisions of the Regulation on Voluntary Health Insurance, the Law of Contracts and Torts, and other provisions of laws of the Republic of Serbia.

2) The Parties shall resolve all disputes amicably and, if they fail to do so, they shall submit to the jurisdiction of the court based on the Insurer's seat.

Article 24.

1) These General Terms and Conditions enter into force on their adoption date, and apply as of September 14th 2016, after having obtained a favorable opinion by the competent state authorities.

2) 4) On the date when these General Terms and Conditions start to apply, the General Terms and Conditions of Voluntary Health Insurance dated January 14th 2015 cease to apply.

NOTE: This is a mere translation of the original Serbian wording, and in case of any discrepancies between the languages, the Serbian wording prevails at all times.