Allianz Hrvatska d.d.

Allianz Best Doctors

General Terms and Conditions

With you from A to Z

Allianz

Allianz Hrvatska d.d.

603-E-0619

Health Care Insurance Allianz Best Doctors General Terms and Conditions

I. Introductory Provisions

Article 1

(1) The health care insurance Allianz Best Doctors General Terms and Conditions (hereinafter: Insurance Conditions) are a fundamental part of the health care insurance contract (hereinafter: insurance contract) signed between the policyholder and Allianz Hrvatska d.d. (hereinafter: Insurer).

II. Basic Terms

Article 2

(1) Definitions of terms in accordance with these Conditions:

Insurer: Allianz Hrvatska d.d. undertakes with the insurance contract to settle its liabilities arising from the insurance contract for the insured risks;

Insurance offerer: the person submitting a written proposal on insurance to the Insurer striving to conclude the insurance contract.

Policyholder: the individual person or the legal entity who has entered into the insurance contract with the Insurer and undertakes to pay the insurance premium. The Policy holder and the Insured can be the same physical person;

Insured: natural person exercising the rights contained in the insurance contract. As an exception, in case of family policies, the Insured can only be the partner/spouse of the policyholder as well as a member of the policyholder's family;

Policyholder's partner: marital or common law partner, if he/she is not under 18 years of age and lives with the policyholder at the same address which can be proven by a certificate of permanent or temporary residence. The partner cannot be a relative of the policyholder. The policyholder may name only one person as a partner. The partner can be a person of the same or opposite gender as the policyholder;

Policyholder's family members: a dependent child of the policyholder or the policyholder's partner (including biological children, partner's children, or adopted children). Permanent address of the dependent child must be the same as the address of the policyholder unless the Insurer requires otherwise. An unwed policyholder's child, over 18, but under 35 years of age, can be insured if:

- the child has no full-time permanent employment or is not self-employed;
- is a full-time pupil/student;
- his/her care and support entirely depends upon the policyholder or policyholder's partner for other reasons.

Further: Further Underwriting International SLU ("Further"), a company that arranges the following medical services associated with the Policy: **Second Medical Opinion** service and **Medical Concierge** service.

- **Second Medical Opinion service:** A second medical opinion in respect of covered conditions. This involves the provision of a second medical opinion report, following the collection and a detailed review of a patient's medical records, by an expert medical specialist.

(This service will be provided by medical services companies such as Best Doctors)

- **Medical Concierge service:** A service whereby Further, in respect of an approved claim arranges all details relating to the medical treatment of an individual. This includes oversight of the case and assistance with travel and accommodation arrangements for the individual and any eligible companion.

Sum insured: the insured amount of money arising from the insurance contract and which Insurer undertakes to pay in case of the occurrence of the insured event;

Compensations: insurance compensation;

Insured event: the event caused by the risk insured;

Coverage: the scope of services and coverage the Insured is entitled to after signing the Allianz Best Doctors insurance contract;

Insurer liability exclusion: legally established circumstances or status not covered by the insurance contract and the Insurer liability. Exclusion shall be applied in accordance with Article 22 of the Insurance conditions;

Policy: written document on the signed insurance contract.

Insurance contract consists of: an offer, policy, Insured health declaration, and Insurance Conditions;

Insured health declaration: a statement signed by the Insured prior to the signing of the insurance contract, establishing that the Insured has no medically confirmed symptoms of the Illnesses covered by the Insurance Conditions and that he/she does not suffer from and was not treated for the same. The signed declaration enables the admission of insurance. Otherwise, the insurance cannot be contracted. If the Insured is a minor, the declaration needs to be signed by a legal representative of the Insured;

Insurance premium: the amount the policyholder shall pay to the Insurer in accordance with the insurance contract;

Expiry: the date of the expiry of the current policy year;

Policy year: a 12- (twelve) month period starting from the insurance contract Commencement Date specified in the insurance policy;

Insurance duration: long-term insurance contract with duration due to the cancellation of one of the parties at least three (3) months prior to the expiry date of the current insurance year.

Hospital: a private or public organization legally authorized to provide medical treatment for Illnesses or bodily Injuries, equipped with the material/technological means and adequate staff to provide diagnosis and surgical interventions, and attended by Doctors and medical staff 24 hours a day.

Hospitalization: an overnight stay at a Hospital or clinic.

Other Illness: an Illness caused by the basic Illness or by a cause connected to the basic Illness is deemed a continuation of the previous Illness, and not a new or separate Illness;

Pre-Existing Conditions: any Illnesses of the Insured which were reported, diagnosed, treated or which showed related (*) medically documented symptoms or findings (signs) within the 10 years prior to the Commencement Date.

(*) For the avoidance of doubt, please note the symptoms or findings (signs) must be strictly related to the relevant condition being considered, and not to an unrelated or separate condition.

Medically Necessary: healthcare services or supplies which are:

prescribed to the Insured for the purpose of treating a Covered Illness or arranging a Covered Medical Procedure with the aim to improve the Insured's medical condition and;

- recognized as effective in improving health outcomes following treatment plans that are consistent in type, frequency and duration with the diagnosis according to published peer-reviewed medical literature (such as Pubmed) or scientifically based US, UK and or European guidelines (specifically, NCCN Clinical Practice Guidelines in Oncology will be applied with respect to Cancer Treatment: Clause III -A) and;
- cost-effective compared to alternative treatments that result in similar outcomes, including no treatment and
- required for reasons other than the convenience of the Insured or his/her Doctor.

The fact that a Doctor may recommend, prescribe, order or approve, a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy

Experimental Treatment: a treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product, intended for medical or surgical use, which has not been universally accepted as safe, effective and appropriate for the treatment of Illnesses or Injuries by the various scientific organizations recognized by the international medical community, or which is undergoing study, research, testing or is at any stage of clinical experimentation;

Alternative Medicine: medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine or the standard treatments, including to: acupuncture, aromatherapy, chiropractic medicine, homeopathic medicine, naturopathic medicine, Ayurveda, traditional Chinese medicine and osteopathic medicine as well as other systems and treatments not acknowledged in traditional medicine.

Prosthesis: A device which replaces all or part of an organ or replaces all or part of the function of an inoperative or malfunctioning part of the body.

Surgery: All operations with a diagnostic or therapeutic purpose, carried out through incision or other means of internal entry, by a surgeon at a Hospital and which normally requires the use of an operating theatre.

Follow-up Care
Any medical care, treatment, Medication or screening service post Treatment Abroad used to:
• identify whether the Insured is likely to suffer from a Disease or Medical Condition in the future or
• prevent the Illness or Medical Condition from occurring or reoccurring in the future
but where no clinical and/or apparent symptoms and/or findings (signs) are currently present.

Medication: Any substance or combination of substances which may be used in, or administered to the Insured either with a view to restoring, correcting or improving physiological functions, or with the purpose of contributing to establishing a medical diagnosis. The medication must be only obtainable with a medical prescription given by a Doctor and dispensed by a licensed pharmacist.
A prescription made for a brand-name Medication is valid for a generic Medication with the same active ingredients, strength and dosage form as the brand-name version.

Reconstructive Surgery:
Procedures that are intended to rebuild a structure in order to correct its loss of function.

Treatment Abroad: Medically Necessary treatment arranged by Further out of Croatia and paid for by this Policy.

Illness: Any alteration or disorder of the body, system, or organ structure or function with identifiable and characteristic set of signs and symptoms, or consistent anatomic alterations. Additionally, a diagnosis has to be made by a Doctor legally registered in his practice.

An Illness will be considered to be all the Injuries and effects arising from the same diagnosis, as well as all the ailments due to the same cause or related causes. If an ailment is due to the same cause that produced a previous Illness or a related cause, the Illness shall be considered as a continuation of the previous one and not as a separate Illness.

Preliminary Medical Certificate: Written approval, issued by Further and/or the Insurer, which includes confirmation of cover under the Policy prior to the Treatment Abroad being performed in the indicated Hospital, for any treatment, services, supplies or prescriptions relating to a Claim.

Cognitive Disorders: Disorders that significantly impairs the cognitive function of an individual to the point where normal functioning in society is impossible without treatment, as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

Consultant Cardiologist: A Doctor is specialized and who is officially recognized as cardiologist by the local medical board in diagnosing and treating diseas

III. Offer and Policy

Article 3

Insurance contract is signed based on a written offer for the Insurer. The offer is the fundamental part of the insurance contract.
Data for the signing of the insurance contract and data on the dangers that affect acceptance or the risk level, and which is required by the Insurer to include in the coverage, must be true and stated in the written offer in an exact and complete manner.

The insurance offer contains important elements for signing the insurance contract, and the Insurer maintains the right to require additional data (e.g. physical examination, medical documentation, etc.) for the purpose of signing the contract.

If the policyholder is not the Insured, the Insurer is entitled to require that the offer be signed by the person who is to be insured on the basis of the offer. In that case the written consent of the Insured shall be provided in the offer or as a separate letter at the signing of the offer with the written sum insured.
Persons under 18 can be insured only upon the consent of a legal representative.

Article 4

(1) The written offer for the signing of the insurance contract for the Insurer obliges the offerer 8 (eight) days from the day when the Insurer received the insurance offer without a medical examination, i.e. 30 (thirty) days if a medical examination is required.
(2) If the Insurer did not reject the offer within the period defined in the previous paragraph of this Article which is within the Insurance Conditions, it shall be deemed that the offer was accepted and that the contract was signed. In that case the insurance is contracted on the day when the offer was delivered to the Insurer.
(3) If the Insurer declares the offer is accepted only under changed conditions, the insurance is contracted on the day when the offerer agreed to change the conditions.
(4) The offerer is entitled to terminate in full the signing of the insurance contract within the deadlines in accordance with paragraph 1 of this Article and request for the return of the premium minus administrative costs if the Insurer did not previously accept the offer or issued a second offer.
(5) If the dangers that affect the acceptance or risk levels, such as illnesses or physical injuries of the Insured, increase within the period between the submittal of the offer and the acceptance of the offer the Insured or the policyholder shall immediately after gaining knowledge inform the Insurer of such events in written form.
(6) The Insurer keeps the right to refuse the insurance offer without stating the reasons for the refusal of the offer, and the offer with the enclosed documentation is not returned to the policyholder.
(7) All changes to the offer and the requirements made by the offerer, policyholder, or the Insurer shall be enclosed in written form, and they are deemed to be submitted on the date when the party they were sent to received them. If the changes are sent via mail, the date of receipt is the date they were submitted at the post office.
(8) The copy of the offer is an essential part of the Insurance contract when the offer is accepted. The signature of the offerer as the policyholder placed on the offer is a signature on the policy.

Article 5

(1) The insurance policy is a document of the signed insurance contract.
(2) The policy contains: the name of the Insurer, name and last name of the policyholder, name and last name of the Insured, date of birth of the Insured, risks covered by the insurance, the insurance commencement and expiry date, sum insured, insurance premium, date of policy issuance, and signatures of the contracting parties.
(3) Alongside the offer, health declaration and policy, an essential part of the insurance contract are the stated Insurance Conditions.

IV. Insurance commencement and expiry date

Article 6

(1) Insurance commencement date can be any day of the month.
(2) The insurance commences at 24.00h of the day stated as the commencement date of the offer and policy provided that the premium or its first instalment has been paid by that date.
(3) If only insurance start date was written in the insurance policy (without expiry date), insurance contract shall be extended from year to year until one of the parties cancels contract according to an Article 25.
(4) The liability of the Insurer begins at the insurance commencement date provided that the premium or its first instalment has been paid by that date. If the premium or its first instalment has not been paid before the insurance commencement, the liability of the Insurer begins at 24.00h on

the day when the contracted premium or its first instalment has been paid in full.
(5) If a waiting period is contracted, the liability of the Insurer begins on the first day after the expiry of the waiting period provided that the due premium is paid.
(6) The insurance expires for each individual Insured with the expiry of the 24th hour on the date:
a. stated in the policy as the insurance expiry date;
b. of the death of the Insured;
c.when the Insured has no legal capacity;
d. when one of the parties terminates the contract according to Article 24 of these Term and Conditions.
e. after the expiry of an insurance year during which the Insured turned 85 (eighty-five) years of age or turns 35 in the case of dependent children;
f. after the expiry of the deadline from Article 12 paragraph 1 of the Insurance Conditions if the premium was not paid by that date.
(7) During the insurance period, insurance premium can be increased in new insurance year according to current Tariff and Insured's new band age. The premiums per band age and concluded Tariff are stated on the Insured's policy. The Insurer does not have the obligation to inform insured about premium changes for the above reasons on the other way, except on the policy..

V. Waiting period

Article 7

(1) During the signing of a new insurance contract, the contracted waiting period is 90 (ninety) days from the insurance Commencement Date stated in the policy or the inclusion date of a new Insured.
(2) During the waiting period the Insured is not included in the coverage and cannot exercise the insurance rights.
(3) If the Illness covered by the Insurance Conditions is diagnosed or if its first, medically confirmed and related (*) symptoms or findings (signs) occur during the waiting period, the Illness is not covered during the entire insurance period.
(*) For the avoidance of doubt, please note the symptoms or findings (signs) must be strictly related to the relevant condition being considered and subject of the Claim, and not to an unrelated or separate condition.
(4) The waiting period is not contracted in insurance renewal if the renewal is performed no later than 30 (thirty) days after the expiry of the previous contract and if the due insurance premium or its first instalment are paid.
(5) If the insurance was not renewed within 30 (thirty) days from the expiry of the previous contract, the waiting period is contracted as a new insurance waiting period and a new health evaluation is conducted based on the health declaration.

VI. Insurance requirements

Article 8

(1) The Insured can be a physically healthy individual who at entry is in his/her 18th to 65th year of age, and with the insurance expiry in his/her 85th year of age at the most. As an exception, if a family policy is being contracted, the Insured can be a child in its 31st day of life up to and including its 17th year of age.
(2) Age at entry is the period between the insurance commencement date and the year of the birth of the Insured.
(3) The Insured can only be a person who:
a) is a permanent/legal resident in Croatia
b) has not, over the previous 10 years, been diagnosed or received treatment of any kind in connection with any of the following illnesses:
I. Any form of cancer, leukaemia, Hodgkin's disease, lymphoma, sarcoma or melanoma;
II. Any:
• precancerous lesions,
• borderline tumour,
• dysplasia,
• elevated tumour marker in the blood (PSA) of 4.0 ng/mL or higher
• abnormal cervical smear or mammogram,
• hyperthyroidism,
• presence of polyps in the colon, small intestine, and/or stomach and a
• any mole or freckle that has bled, become painful, changed colour or increased in size
…from which he/she has not fully recovered and/or been discharged from follow up;
III. Any blood disorder or inherited immune disorder needing treatment over a period of more than one month which required regular or continuous treatment other than just a special diet (for example aplastic anaemia, lymphoma, leukaemia, myeloma, myelodysplastic syndrome, sickle cell disease, thalassemia);
IV. Any kind of:
• tumour, lump, cyst or
• vascular or circulatory condition including stroke, transient ischemic attack (TIA), brain haemorrhage (bleeding), abnormal blood vessels (arteriovenous malformation, aneurysm, thrombus or embolus in the brain)

in or around the brain;
V. Any form of heart disease (including heart attack, angina, heart vessel disorders, heart valve disorders, heart murmurs or rheumatic fever, heart failure, heart enlargement or cardiomyopathy). Please note high blood pressure and/or high cholesterol can be disregarded;
VI. Diabetes. Please note gestational diabetes can be disregarded;
VII. Chronic impaired kidney function, dialysis, liver cirrhosis or chronic liver failure.

a) Has not had any of his/her natural parents, brother or sisters, before their 50th birthday, been diagnosed with cardiovascular disease (heart attack, bypass surgery or stroke), polycystic kidney disease, or cancer of the bowel, breast, colon, ovarian, prostate, melanoma, pancreas or kidney.
b) Is not currently or did not suffer during the last 6 months from any persisting or recurrent symptoms and/or signs which have not yet been investigated.
This includes any lump in the breast or in testicles, rectal bleeding, blood in urine, unusual cough, jaundice, unexplained weight loss, headaches of increasing frequency, vision disturbances (blurry/double vision, unexplained vision loss), unexplained hearing loss, speech difficulties, weakness of limbs, seizures, fits or fainting and abnormal lab values of your blood check.
c) Is not currently in the process of scheduling or has not scheduled a doctor or hospital appointment whose purpose is to share or discuss any of the symptoms mentioned in question d) above; or is currently awaiting the results of any tests, procedures or analyses for such symptoms or findings.
d) Has not scheduled an appointment for breast magnetic resonance imaging (MRI) in the last 12 months?
e) Has not had or been recommended to have, or is not currently on a waiting list for an organ transplant.
(4) Persons who have no legal capacity cannot be insured.

VII. Form of insurance contract

Article 9

(1) Insurance contracts and all annexes are valid only if contracted in written form.
(2) All of the requirements or statements are submitted in a timely manner if they are submitted within the deadline provided in the provisions of the Insurance conditions.

VIII. Insurance premium

Article 10

(1) Insurance premium is determined in accordance with the tariff of the Insurer, and it depends on the age at entry of the Insured.
(2) When renewing insurance, the Insurer keeps the right to change insurance premiums if there are changes in the parameters that affect the premium level, such as: the medical services market price; changes in legislation that affect the premium levels; or a change in the Best Doctors service prices. In that case, the Insurer shall notify the policyholder in writing no later than 30 days before the insurance contract expiry date.
(3) If the policyholder does not accept the premium changes within 30 (thirty) days from the day he/she received the written note, the insurance contract shall not be renewed.

Article 11

(1) Insurance premium and sum insured are contracted in EUR and paid in HRK.
(2) The premium is converted to EUR based on the HRK countervalue in accordance with the selling rate of the Croatian National Bank (HNB) on the invoicing date.
(3) The premium is paid in advance once a year or in installments within

the deadlines established in the insurance offer and in accordance with the tariff of the Insurer. A discount is granted, in accordance with the valid tariff, for annual payments.
(4) The policyholder shall pay the premium in time with the contracted deadlines and in a contracted manner.
(5) The premium is paid at the cash desk of the Insurer, via mail or at a bank. The premium is paid on the day when the payment is made to the business account of the Insurer or when the payment is made at the cash desk of the Insurer.
(6) The premium shall be paid in full without lowering the amount by payment operations costs.
(7) The Insurer is entitled to charge default interest determined by law for each day of delayed premium payment.
(8) The Insurer shall accept the premium from any person that has a legal interest in paying the premium.
(9) The Insurer is entitled to, in paying compensations on the basis of the insurance contract, reduce the insurance premium by the due, but unpaid, premium for a policy, and default interest determined by the law, as well as unpaid premium for a policy for the underwriting year when the insured event occurred.

IX. Consequences for not paying the premium

Article 12

(1) If the policyholder, after receiving a call from the Insurer delivered by way of registered letter, fails to pay the due premium before the deadline stated in the letter, which shall be no shorter than 30 (thirty) days including the time when the letter was delivered, and if no other interest person does so, the Insurer is entitled to state to the policyholder that the contract is terminated.
(2) In each case the insurance contract is terminated under the law if the premium is not paid within a year after the due date.
(3) The premium contracted for the current year of the insurance belongs to the Insurer after the termination of the insurance before the contracted expiry date due to the compensations payment or fulfilling the Insurer's obligation from the insurance contract. In other cases of insurance contract termination prior to the contracted deadline expiry, the Insurer is entitled to the premium only until the end of the final date of the insurance.

X. Manner of Notification

Article 13

(1) The policyholder shall immediately send a notification of the change of permanent address, residential address, and place of premium payment. Otherwise, the Insurer is entitled to send written notifications to the last address of the policyholder that was delivered to the Insurer.
(2) All of the provisions within the notifications sent by the Insurer in a manner determined in the previous paragraph of this Article shall come into force on the date when the notifications are sent to the post office and are treated as if the policyholder received them.
(3) All changes to the offer, requirements, notifications, or statements made by the offerer, policyholder, or the Insurer shall be in written form and shall be deemed submitted on the date when they were received by the party they were sent to. If the same are sent via mail, the date of receipt is the date they were submitted at the post office.

XI. Insured event

Article 14

(1) The insured event is the Illness of the Insured diagnosed by an authorised doctor of the Insured during the insurance contract period provided that the following conditions are fulfilled:

- The procedure is performed during the period of cover;
- It is a diagnosis that has a treatment requiring medically justified medical treatment or procedure that is covered by the Insurance Conditions;
- The first related(*)symptoms or findings (signs) of the diagnosed Illness did not occur before the insurance commenced or during the waiting period or (in case of family or group insurance) before the date the Insured was included in the insurance; (*) For the avoidance of doubt, please note the symptoms or findings (signs) must be strictly related to the relevant condition being considered subject of the Claim, and not to an unrelated or separate condition.
- The Illness is not a Pre-Existing Condition
- The diagnosed Illness was reported to the Insurer during the insurance period or within the valid legal deadlines;
- Insured is permanent/fiscal resident in the Republic of Croatia at the time of claim notification.
- The treatment is arranged by Further in accordance with the Claims Procedure set out in Article 21
- The medical expenses arise outside the Republic of Croatia with the exception of the Medication expenses covered in Article 15, paragraph E1.
- The expenses for any medical diagnostic procedures, treatment, services, supplies or prescriptions are covered by the Policy as stated in Article 15

(2) The medical treatment and procedures related to the diagnoses covered by the conditions and
in accordance to paragraph 1 of this Article are:

a) Cancer treatment
The treatment of:
1. Any malignant tumour including leukaemia, sarcoma and lymphoma characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
2. Any pre-cancerous change in the cells that are cytologically or histologically classified as high-grade dysplasia or severe dysplasia.
3. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues
b) Coronary artery by-pass surgery (myocardial re-vascularisation)
The undergoing of Surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.
c) Heart valve replacement or repair
The invasive replacement or repair of one or more heart valves, independent whether this is performed with open chest surgery, minimally invasive or by means of cardiac catheter treatment on the advice of a Consultant Cardiologist
d) Inter-cranial and specific spinal cord surgery
- Any Surgical intervention of the brain or any other intracranial structures;
- Treatment of benign tumours located in the spinal cord (Medulla spinalis)

e) Live-donor organ Transplant
Meaning a Surgical transplant in which the Insured receives a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.
f) Bone Marrow Transplant
Meaning the Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from:
- the Insured (Autologous bone marrow transplant); or
- from a living compatible donor (allogeneic bone marrow transplant).

Please note that Haemopoietic Stem Cell transplantation (HCT) using the umbilical cord blood will be excluded.

XII. Insurer liability scope

Article 15

(1) If, during the insurance period, an insured event occurs as defined in Article 14 paragraph 1, the Insurer obliges to pay medical treatment expenses or expenses for providing medical services to the Insured only outside of the territory of the Republic of Croatia with the exceptions stated in Article 22 of the Insurance Conditions. Those are the following expenses:

a) SERVICES COVERED prior to receiving Treatment Abroad
1. Second Medical Opinion service: The Insured will be entitled to request to Further , at the point of Claim notification, a Second Medical Opinion service for confirmation of the diagnosis of a Covered Disease or Medical Procedure and the assessment of the optimal treatment plan.
2. The Second Medical Opinion service can only be requested once per Claim.

b) MEDICAL EXPENSES COVERED during Treatment Abroad
1. Hospital expenses related to the medical service:
1.1 Accommodation, meals, and general nursing services provided during the Insured´s stay in a room, ward, or section of the Hospital or in an intensive care or monitoring unit, all of which is primary care standard;
1.2 Other Hospital services including those provided by a Hospital outpatient department, as well as expenses relating to the cost of an extra or companion's bed if the Hospital provides this service;
1.3 The use of an operating room and all the services included in it.

1. By a day clinic or independent welfare centre, but only if the treatment, Surgery or prescription would have been covered under this Policy if provided in a Hospital.
2. By a Doctor, in respect of examination, treatment, medical care or Surgery.
3. For Doctors' visits during Hospitalization.
4. For the following medical and surgical services, treatments or prescriptions:

5.1 For anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist;

5.2 Laboratory analysis, pathology and x-rays for treatment preparation purposes, radiotherapy, radioactive isotopes, chemotherapy, electrocardiograms, echocardiography, myelograms, electroencephalograms, angiograms, computerized tomography and other similar tests and treatments required for the treatment of a Covered Disease or Medical Procedure, when performed by a Doctor or under medical supervision;

5.3 Blood transfusions, administration of plasma and serum;

5.4 Expenses relating to the use of oxygen, application of intravenous solutions and injections.

4.5 Radiation therapy: high-energy radiation to shrink tumours and kill cancer cells by X-rays, gamma rays, and charged particles are types of radiation used for cancer treatment either delivered by a device outside the body (external-beam radiation therapy), or by radioactive material placed in the body near cancer cells (internal radiation therapy, brachytherapy).

5. Reconstructive Surgery to repair or rebuild a structure damaged or removed by the medical procedures arranged and paid for by this Policy.
6. Treatment for complications or side-effects directly associated with the medical procedures arranged and paid for by this Policy that:
a) demand immediate medical attention in a Hospital or clinical setting and
b) require to be addressed prior to the Insured being declared medically fit to travel to return to the Republic of Croatia after the completion of the stage of Treatment Abroad.
7. For Medication applied by medical prescription while the Insured is Hospitalized for treatment of a Covered Illness or Medical Procedure. Medication prescribed for post-operative treatment are covered for 30 days from the date the Insured has completed the Treatment Abroad stage of the treatment and only when these are purchased prior to returning to the Republic of Croatia.
8. For transfers and transportation by ground or air ambulances where their use is indicated and prescribed by a Doctor and pre-approved by Further.
9. For services provided to a living donor during the process of removal of an organ to be transplanted to the Insured, arising from:
10.1 The cost of the analysis and test performed to identify the suitable donor within the family members of the Insured;
10.2 Hospital services provided to the donor, including accommodation in a Hospital room, ward or section, meals, general nursing services, regular services provided by Hospital staff, laboratory tests and use of equipment and other Hospital facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);
10.3 For Surgery and medical services for the removal of a donor's organ or tissue to be transplanted to the Insured.
10. For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the Insured. Cover will only be provided for expenses incurred from the date of issue of the Preliminary Medical Certificate.

c) NON-MEDICAL EXPENSES COVERED during Treatment Abroad

c1) TRAVEL EXPENSES for Treatment Abroad

1. For travel abroad of the Insured and travelling companion (or two companions, when the Insured receiving treatment is a minor) and where applicable the living donor in the case of transplant with the sole purpose of receiving Treatment Abroad as approved by Further in the Preliminary Medical Certificate.
2. Insurer i.e. Further will be responsible for deciding the travel dates based on the approved treatment schedule.
3. In the event that the Insured changes the travel dates from those communicated by Insurer i.e. Further the Insured will need to compensate the Insurance Company and/or Further for all the associated costs of organizing and providing new travel arrangements, unless the changes have been confirmed by Further as necessary from a medical standpoint.
4. The travel expenses covered will include:
• Transportation from the Insured's permanent address to the designated airport or international rail station.
• Economy class rail or air ticket to the city of treatment destination and the transportation to the designated hotel.
• Transportation from the designated Hotel or Hospital to the designated airport or international rail station.
• Economy class rail or air ticket and subsequent transportation to the city of the Insured's permanent Address in the Republic of Croatia.

1. The travel expenses covered will not include regular transfers from the hotel to the Hospital or treating Doctor during the duration of the Treatment Abroad.

c2) ACCOMMODATION EXPENSES during Treatment Abroad

1. For the accommodation, outside the Republic of Croatia, of the Insured, travelling companion (or two companions, when the Insured receiving treatment is a minor) and the living donor in the case of transplant, with the sole purpose of receiving treatment as approved by Further in the Preliminary Medical Certificate.
2. Insurer i.e. Further will be responsible for deciding the accommodation booking dates based on the approved treatment schedule.
3. Insurer i.e. Further will provide a return date based on the completion of the treatment and the agreement with the treating Doctor that the Insured is fit to travel.

4. In the event that the Insured changes the dates of travel from those booked and communicated by Insurer i.e. Further the Insured will need to compensate the Insurance Company and/or Further for all the associated costs of organizing and providing new accommodation arrangements, unless the changes have been confirmed by Insurer i.e. Further as necessary from a medical standpoint.
5. The accommodation arrangements will include bookings for a double room or twin bed room in a three- or four-star hotel including breakfast. (the choice of hotel will be subject to availability and based on the proximity to the hospital or treating Doctor within a radius of 10 km.)
6. Meals (excluding breakfast) and incidental costs at the hotel are not covered. Upgrades in the hotel cannot be financed by the Insured.

c3) Repatriation Expenses
1. In the event the Insured (and/or living donor in the case of transplant) dies outside the Republic of Croatia while receiving the treatment approved by Further in the Preliminary Medical Certificate, the Insurance Company will pay for the repatriation of the deceased's remains to the Republic of Croatia.
2. This coverage is limited to only those services and supplies necessary to prepare the deceased´s body and to transport to the Republic of Croatia, including:
• The services provided by the funeral company providing the international repatriation, including embalmment and all administrative formalities.
• The minimum obligatory coffin
• The transport of the deceased's remains from the airport to the designated place of burial in the Republic of Croatia.

d) MONETARY BENEFITS COVERED during Treatment Abroad
1. The daily indemnity is covered in the amount established by the insurance policy for each night spent at the hospital that was authorised by the Insurer, i.e. Further in the Preliminary Medical Certificate (authorisation letter) issued for the purpose of a medical treatment of the Illness or to conduct a medical procedure, but for no longer than 60 days per claim/ insured event.

e) MEDICAL EXPENSES COVERED after returning from Treatment Abroad

e1) MEDICATION EXPENSES after returning from Treatment Abroad
1. If, during the insurance period, an insured event occurs as defined in Article 14 paragraph 1, the Insurer obliges to cover Medication costs incurred on the territory of the Republic of Croatia with the exceptions stated in Article 22 of the Insurance Conditions.

2. For the cost of Medication purchased in the Republic of Croatia, following treatment of a Covered Illness or Medical Procedure approved by Insurer i.e. Further in the Preliminary Medical Certification and paid for under the Policy with duration of more than 3 nights of Hospitalization outside the Republic of Croatia.
3. Cover under the Policy for this Benefit is only available on the following basis:
• That the Medication has been recommended through Insurer i.e. Further by the international Doctor(s) that treated the Insured, as necessary for on-going treatment.
• The Medication has been licensed and approved by the corresponding medical authority or agency in the Republic of Croatia, and its prescription and administration is regulated
• The Medication requires prescription by a Doctor in the Republic of Croatia.
• The Medication is available for purchase in the Republic of Croatia.
• That no prescription exceeds a dose for consumption longer than 2 months.
4. The Medication costs cover the parent drug as well as the generic medicine made out of the same ingredients, with same potency and dosage as the parent drug.
5. The purchase of the Medication for this section E1) needs to be arranged and paid directly by the Insured. The Insurance Company will reimburse the Insured upon receipt of the relevant prescription, original invoice and proof of payment.
6. Where the cost of Medication has been funded in part by the Public Health Service of the Republic of Croatia or an insurance Policy, the reimbursement request should clearly differentiate those costs partially funded by the Insured.

e2) FOLLOW UP CARE after returning from Treatment Abroad

1. Follow Up Care can be arranged by Further at the request of the Insured to be performed by the international Doctor(s) that treated the Insured or their medical team.
2. Follow-up Care is covered for 180 days from the date the Insured returns to the Republic of Croatia after having completed the stage of Treatment Abroad and only when the treatment is prescribed or recommended through Further and by the international Doctor(s) that treated the Insured.
3. Should the Insured make this request, Further will also arrange the necessary travel and accommodation arrangements on the terms described in Article 15 paragraphs C1 & C2 for the Insured and designated companion(s).

Article 16
(1) After the occurrence of the Insured event, the Insurer shall pay compensations determined in the Insurance contract and/or initiate the organisation of the medical treatment of the Insured abroad within 14 (fourteen) days from the day the claim and the required documentation were received.
(2) If a specific period of time is required in order to establish if there is Insurer liability or to establish the amount of the liability, the Insurer shall pay the compensations determined in the contract within 30 (thirty) days from the day the claim was received or send a notice in the same period of time that the request was not grounded.
(3) If the Insurer liabilities are not established within the deadlines set in paragraphs 1 and 2 of the Article, the Insurer shall immediately pay the amount of the undisputed liability share by the amount of the in advance payment.
(4) If the Insurer does not fulfil its obligation within the deadlines set in this Article, the Insurer shall pay to the Insured the default interest determined by the law as well as compensation for damages caused.

XII. Obligations of the policyholder

Article 17
(1) When signing the insurance contract, the policyholder shall report to the Insurer all the circumstances important for risk assessment that he/she is already aware or should have known of.
(2) If the policyholder deliberately made a false application or did not state a specific circumstance that, had the Insurer known of the circumstance, would prevent the Insurer from signing the contract, the Insurer is entitled to request for a termination of the contract.
(3) If the Insurer, when terminating the contract, returns the paid insurance premium, the Insurer is not obliged to pay the medical treatment expenses, i.e. the compensations if the insured event occurs before the day the termination request was submitted.
(4) If the Insurer, in case of contract termination, keeps the insurance premium paid before the day the termination request was submitted or charges the insurance premium, the Insurer is obliged to pay the medical treatment expenses, i.e. the compensations if the insured event occurs before that date.
(5) The Insurer's right to request for a termination of the insurance contract is no longer valid if within 3 (three) months from the date of discovering the false application or the omission of a circumstance the Insurer fails to introduce the policyholder of the intent to exercise that right.

Article 18
(1) If the policyholder has provided false information or failed to give a required notification, but not on purpose, the Insurer can chose to, within a month after gaining knowledge of the false or incomplete information, make a statement of contract termination or propose a premium increase in proportion to the increased risk.
(2) In the occurrence of the event stated in paragraph 1 of this Article, the contract shall end 14 (fourteen) days after the date when the Insurer made the statement on terminating the insurance to the policyholder, and in case of the insurer's proposal to increase the premium, the termination shall legally occur if the policyholder refuses the proposal 14 (fourteen) days after the receipt of the proposal.
(3) In case of contract termination within the meaning of paragraphs 1 and 2 of this Article, the Insurer shall return that part of the premium regarding the period until the cancellation of the insurance.
(4) If the insured event occurs before the false or incomplete application was discovered or after that, but before the termination of the contract, i.e. before the contract on the premium increase, the compensation is reduced in proportion to the paid premium and the premium to be paid in accordance to the actual risk.
(5) If the Insurer, during the signing of the contract, was aware or should have been aware of the circumstances important for risk assessment, which were falsely stated or not reported by the policyholder, the Insurer cannot invoke the false application or concealment.

Article 19
(1) During the insurance period policyholder is obliged, without delay, to report to Insurer any change of employment (or a job) and change the status of dependent family member, permanent address of insured persons and residential address which will have affect on the risk assessment of Insurer.
(2) In the event of the above paragraph of this Article, the insurance contract shall be terminated upon termination of the current insurance year.

XIV. Notification on the insured event

Article 20
(1) The policyholder/Insured or his/her legal representative is obliged to immediately notify the Insurer on the occurrence of the insured event.
(2) The insured event must be immediately reported, only to the Insurer's Customer Service on the telephone number: 072 100 001 or via e-mail: allianzbd@allianz.hr
The application form is available on the Insurer's website: www.allianz.hr
(3) After the insured event is reported in accordance with the previous paragraph of this Article, the Insurer, i.e. Further shall contact the Insured and initiate the Second Medical Opinion service procedure. The Insurer can be offered a medical treatment abroad only on the basis of a medical report and a second doctor's opinion acquired during the the Second Medical Opinion procedure. For the purposes of conducting the Second Medical Opinion procedure, the Insured is required to fulfill the necessary forms, including a written statement by the Insured granting permission to the Insurer and Further to ask for relevant diagnostic tests and medical data as well as providing the Insurer and Further with all the necessary information on the diagnosis supported by the medical documentation in the Insured's possession.
(4) Should the Insured request the Second Medical Opinion service, this service will need to be completed prior to confirmation of cover of the Claim under the Policy.

7

XV. The filing procedure and settling the claims

Article 21

1 Obligation Of The Insured

a) The Insured is obliged to cooperate with Further providing free access to medical documents in the possession of the Insured or the Doctors, Hospitals or other medical facilities responsible for treatment up to the date the potential Claim was notified.

b) Any Claim request will only be evaluated for cover under the Policy when all the necessary information has been received from the Insured and respective Doctors, Hospitals or other medical facilities.

2 Claim Assessment and Proposal Of Hospital For Treatment

a) Upon receipt of all the relevant diagnostic tests and medical history as requested by Further, the Insured will be notified if the Claim is covered under the Policy.

b) In the event that the Insured wishes to consider Treatment Abroad, the Insured will be provided with a list of recommended Hospitals.

3 Treatment Abroad: The Preliminary Medical Certificate

a) Upon receipt of the Insured´s confirmation of his/her decision to receive treatment abroad at a Hospital selected from the list of recommended Hospitals for treatment, Further will arrange through the Medical Concierge service the necessary logistical and medical arrangements for the correct admission of the Insured and a Preliminary Medical Certificate will be issued valid only for that Hospital.

b) The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured at the time of issue. Since the health condition of the Insured may change over time, both documents will have a validity of three months.

c) In the event that the Insured does not select a Hospital from the list of recommended Hospital or does not initiate treatment at the approved Hospital stated in the Preliminary Medical Certificate within three months of issue, new versions of these documents may be reissued based on the health condition of the Insured at that time.

d) As long as the terms of the Preliminary Medical Certificate are met, the Insurer, under the Benefits of the Policy, will directly assume the medical expenses covered in Article 15 paragraph B and the necessary travel and accommodation arrangements detailed in Article 15 paragraph C1 & C2 subject to the limitations, exclusions and conditions detailed in the Policy.

4 Return from Treatment Abroad

a) The Treatment Abroad stage of treatment will end on the confirmation by Further that no further Medically Necessary treatment is prescribed by the international Doctor(s).

b) Following the completion of the Treatment Abroad stage of the treatment Further will arrange for the final return of the Insured and companion(s) to the Republic of Croatia and will present the Insured with the guidelines to benefit from the covered medical expenses after returning from Treatment Abroad as detailed in Article 15. These guidelines will be based on the recommendations from the international Doctor(s).

c) Upon arrival of the Insured to the Republic of Croatia, the Insured will be entitled to:

• be refunded for the medication expenses detailed in Article 15 paragraph E1 and

• request Further to arrange for Follow Up Care as detailed in Article 15 paragraph E2 during the following 180 days.

5 Assessment of Claims After Return From Treatment Abroad

a) Upon the final return of the Insured to the Republic of Croatia, after receiving Treatment Abroad as detailed in paragraph 4 of this Article 21, the evolution of the Insured´s health state may determine that a new assessment for further Medically Necessary treatment may be required. Provided the Insured's Policy is still active at this time, the Insured will be entitled to contact Further to complete this assessment.

b) Further will then confirm again to the Insured of the steps required to provide Further with all the relevant diagnostic tests and medical documents necessary to complete this assessment.

• In the event that the assessment by Further confirms that further Medically Necessary treatment is required due to the same Illness or Covered Medical Procedure previously treated by the Policy, this will be assessed by Further (as detailed in Article 21 paragraph 2), confirmed to the Insured by issuing a new Preliminary Medical Certificate, with the resulting list of recommended Hospitals and potential Treatment Abroad (as detailed in Article 21 paragraph 3 & 4), being considered as a continuation of the same Claim.

The assessment may require, when medically justified in the view of Further, the completion of a new Second Medical Opinion service.

After the final return of the Insured to the Republic of Croatia after receiving this new episode of Treatment Abroad, a new period of 180 days will be established for Follow Up Care as detailed in Article 15 paragraph E2.

• In the event that the assessment by Further establishes that this new request is related to a different Illness or medical procedure and therefore unrelated to the previous Claim, this scenario will be considered as a new and separate potential Claim, and the entire process detailed in Articles 20 and 21 will need to be followed.

6 Payment

a) As long as the conditions from the Preliminary medical certificate (authorisation letter) are followed, the Insurer shall, in accordance with the signed insurance contract, accept the expenses of the Insured made in accordance with the Insurance Conditions.

b) In order to establish the amount and scope of the liability, the Insurer or Further are entitled to request all the necessary documentation from the Insured. The Insured shall bear the costs for the acquisition of the required documentation. The Insurer is not liable for the acquisition of the required documentation that is the basis for the compensation payment.

c) The policyholder / Insured grants permission to the Insurer to examine if the service was used for which the provider of the services requires payment.

d) In filing a request for the reimbursement of the medication costs acquired in the Republic of Croatia, the policyholder / Insured shall deliver to the Insurer the original paid receipts, prescription or copies, and the related medical documentation.

XVI. Insurer liability exclusion

Article 22

(1) Insurance contract is null and void if, at the moment of contracting, the insured event has already occurred or has been in the process of occurring, or if there was certainty that it would occur, and the paid premium is returned to the policyholder minus the Insurer's costs.

(2) The following Insurer liabilities are excluded in full:

a) Generic Exclusions

1. Expenses derived from all Illnesses or Medical Procedures not specifically contemplated under articles 14. and 15. ff this Terms and Conditions
2. Any expenses for Illnesses or Injuries produced as a result of wars, Acts of Terrorism, seismic movements, commotions, riots, floods, volcanic eruptions, as well as the direct or indirect consequences of nuclear reaction and any other extraordinary or catastrophic phenomena; as well as officially declared epidemics.
3. Any healthcare expenses required due to alcoholism, drug addiction and/or intoxicants caused by the abuse of alcohol and/ or the use of psychoactive, narcotic or hallucinogenic drugs. Also excluded are the consequences and Illnesses arising from attempted suicide and self-harm.
4. Expenses derived from all Illnesses or conditions caused intentionally or fraudulently or derived from acts of negligence or criminal imprudence by the Insured or resulting when committing a crime.
5. A Claim where the Insured, prior to, during or after the Claim assessment process established by Further:

 has not followed the advice, prescriptions or established treatment plan of the treating Doctor or

 refuses to receive any medical treatment or be subject to additional diagnostic analysis or tests necessary to establish a definitive diagnosis or treatment plan.

b) Medical Exclusions

1. Pre-Existing Conditions or Other Illness caused or related(*) to them that were diagnosed, reported, treated or showing first related medically documented symptoms or findings (signs) during the 10-year period prior to the Commencement date.

(*) For the avoidance of doubt, please note the conditions, symptoms or findings (signs) must be strictly related to the relevant condition being considered subject of the Claim, and not to an unrelated or separate condition.

2. Experimental Treatment as well as those diagnostic, therapeutic and/or surgical procedures whose security and reliability have not been duly scientifically proven.
3. Medical procedures needed as a result of AIDS (acquired immune deficiency syndrome), HIV (human immunodeficiency virus) or any condition arising from them (including Kaposi's sarcoma), or any treatment for AIDS or HIV.
4. Any service that is not Medically Necessary for the treatment of a Covered Illness or Medical Procedure, as described in Article 14.
5. Any alternative treatment, service, supply or medical prescription for an Illness or Medical Condition for which the best treatment is a transplant covered by the Policy (Article 14 paragraphs 2e & 2f).
6. Any Illness or Medical Condition which has been caused by the medical procedures arranged and paid for by this Policy save where the Illness or Medical Condition in question is a Covered Illness or requires a Covered Medical Procedure contemplated under Article 14.
7. Treatment for long-term side effects, relief of chronic symptoms, or rehabilitation (including but not limited to physiotherapy, mobility rehabilitation, and language and speech therapy).
8. In relation to the Medication expenses covered after returning from Treatment Abroad (Article 15 paragraph E1), the following exclusions apply:
• Any cost of Medication which is totally funded by the Public Health Service of the Republic of Croatia or that is covered by any other insurance policy held by the Insured.
• The cost of the administration of the Medication.
• Any purchase of Medication incurred outside the Republic of Croatia.
Invoices submitted to the Insurance Company more than 180 days after purchase of the Medication.

c) Excluded Expenses
1. Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature when the insured, at the point of the relevant claim notification date, cannot be considered a permanent/legal resident in the Republic of Croatia
2. Any expense incurred in respect of any Illness diagnosed, reported, treated or showing their first related (*) medically documented symptoms or findings (signs) during the Exclusion Period. (*) For the avoidance of doubt, please note the illnesses, symptoms or findings (signs) must be strictly related to the relevant condition being considered subject of the Claim, and not to an unrelated or separate condition.
3. Any expense incurred before the issuance of the Preliminary Medical Certificate.
4. Any expense incurred in a different Hospital from the authorized and mentioned in the Preliminary Medical Certificate.
5. Any expense incurred without following Article 14 i 15
6. Any expense incurred in respect of confinement services, home health care or services provided in a convalescence centre or institution, hospice or old people's home, even where such services are required or necessary as a result of a Covered Illness or Medical Procedure.
7. Any expense incurred in the purchase (or hire) of any type of Prosthesis or orthopaedic appliances, corsets, bandages, crutches, artificial members or organs, wigs (even where their use is considered necessary during chemotherapy treatment), orthopaedic footwear, trusses and other similar equipment or items, with the exception of:
   a) breast prostheses as a result of mastectomy Surgery arranged and paid for by the Policy and
   b) prosthetic heart valves as a result of Heart valve replacement or repair arranged and paid for by the Policy.

8. Any expense incurred in the purchase or hire of wheelchairs, special beds, air conditioning appliances, air cleaners and any other similar items or equipment.
9. All Medication which has not been dispensed by a licensed pharmacist or which are obtainable without a medical prescription.
10. Any cost of Medication covered in Article15. Paragraph E1. which is funded by the Public Health Service of Croatia or that is covered by any other insurance policy held by the Insured.
11. The cost of the administration related to the Medication expenses covered in Article15. Paragraph E1.
12. Any purchase of Medication covered in Article15. Paragraph E1incurred outside the Republic of Croatia.
13. Invoices submitted to the Insurance Company more than 3 years after purchase of the Medication covered in Article15. Paragraph E1
14. Any charges made for the use of Alternative Medicine, even where specifically prescribed by a Doctor.
15. Any charges for medical attention or confinement in cases of Cognitive Disorders, senility or cerebral impairment, regardless of the status of their development.
16. Interpreter's fees, telephone and other charges in respect of items for personal use or which are not of a medical nature, or for any other service provided to relatives, companions or escorts.
17. Any expense incurred by the Insured or the relatives, companions or escorts, except those expressly covered.
18. Any expenses in respect of accommodation or transportation arranged by the Insured, travelling companion or a living donor.
19. Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature incurred worldwide when the Insured, at the point of the relevant claim notification date, cannot be considered a permanent/legal in the Republic of Croatia .

d) Excluded Illnesses and Medical Procedures

1. In the case of Cancer Treatment (Article 14, paragraph 2a)
1.1. Any tumour in the presence of AIDS (Acquired Immune Deficiency Syndrome).
1.2. Any non-melanoma skin cancer that has not been histologically classified as having caused invasion beyond the epidermis (the outer layer of the skin).

2. In the case of Coronary Artery By-Pass Surgery(Article 14, paragraph 2b)
2.1. Any coronary disease treated using techniques other than the by-pass of the coronary arteries, like any kind of angioplasty Surgery, stents.

3.In the case of Live-donor organ transplant (Article 14, paragraph 2e)
3.1. Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.
3.2. Any transplant when the transplant is conducted as a self-transplant.
3.3. Any transplant when the Insured is a donor for a third-party (not covered by the Policy)
3.4. Any transplants from a dead donor (cadaveric transplantation).
3.5. Any organ transplant that involves Stem Cells treatment.
3.6. The transplant made possible by the purchase of donor organs.

XVII. Statute of limitations

Article 23
(1) The insurance contract claims have a limitation period in accordance with the provisions of the Civil Obligations Act.

XVIII. Insurance Conditions modification

Article 24
(1) The Insurer has the right to modify the Insurance Conditions during the insurance period.
(2) If the new Insurance Conditions apply to the previously signed contracts, the Insurer shall, in writing or any other appropriate manner, inform the policyholder no later than 30 days before the new insurance year.
(3) The policyholder is obligated, before the new Insurance Conditions become valid, to inform the Insurer in written form that he/she accepts the new terms and conditions of the contract. It will be considered that the policyholder accepts new insurance terms and conditions if the insurance premium is paid until due date.
(4) Otherwise, the insurance contract will be terminated at the end of the current insurance year.
(5) In the case when Insurer gives proposal for premium's increase, provisions of paragraph 1.-4. of this article will be analog applied.

XIX. Cancelling the contract

Article 25
(1) If the contract is concluded as long-term contract each contractual party can, if the contract is not terminated due to contractual reasons, cancel the insured contract. Cancel of the agreement should be send to other party in

writing form at least 3 months prior to the expiry of the current insurance year. The contract will be canceled on the expiry date of the current insurance year.

XX. Out-of-court dispute settlement

Article 26

(1) The parties agree to try to settle all disputes arising from the insurance in a peaceful manner;

(2) The policyholder, the Insured, and the beneficiary are obliged to immediately inform the Insurer on any matters in dispute, complaints, and misunderstandings arising from the insurance;

(3) Notifications from the previous paragraph of the Clause are to be delivered by the offerer in written form that can be used to establish the notification content, the signature of the notifier, and the time when the notification was sent;

(4) The Insurer, policyholder or beneficiary from the insurance contract can make his/her complaint to the Insurer against the Insurer's decision or proceeding either orally on the record (both, complaintant and recipient of the complainant have to be present) or submit a written complaint:

· per post to the address: Allianz Hrvatska d.d., Služba za kontakte s klijentima, Heinzelova 70, Zagreb

· by fax calling the number: 01/4653-533

· by email by sending an e-mail to the following e-mail address: osiguranje@allianz.hr

· via web form at www.allianz.hr · personally at a point of sale of the Insurer

(5) The complaint must contain:

a) name, last name, and address of the applicant who is a physical person or his/her legal representative, i.e. the company, seat, name and last name of the person responsible for the applicant that is a legal entity;

b) reasons for the complaint and the applicant's requests;

c) evidence verifying the complaint statements if possible, to send, and which can contain documentation that was not taken into consideration in the decision-making process due to which the complaint is filed, as well as proposals for a presentation of evidence;

d) the date the complaint was filed and the signature of the applicant, i.e. the person representing the applicant;

e) power of attorney if the complaint was filed by an attorney at fact.

(6) The deadline for the filing of a complaint against a decision or a process made by the company is 15 (fifteen) days from the date the applicant received the decision he/she is complaining against, i.e. the day he/she gained knowledge of the reason for the complaint.

(7) Complaints are solved by the Customer Contact Service in cooperation with the relevant organizational unit. The insurer is obliged to respond to the complaint no later than 15 days after the receipt of the complaint. If the complaint has been received in written form, Insurer is obliged to send a reply in written form as well. If the complaint is filed by e-mail or the complainant asks for it, the response to the complaint may be sent by e-mail.

(8) When the response to the complaint does not meet or does not fully meet requirements of the complaints, the Company's position with regard to the complaint should be explained to the complainant, and the complainant has the right to:

a) file a complaint to the ombudsman for breach of the Code of Insurance and Reinsurance Business Ethics Code,

b) initiate a procedure for peaceful settlement of disputes, for example before the Conciliation Center at the Croatian Chamber of Commerce and/or the Conciliation Center at the Croatian Insurance Bureau,

c) file a lawsuit with the competent court

(9) All disputes arising out of, or in connection with, the insurance relationship, including disputes relating to the issues of its occurrence, breach or termination, as well as the legal effects arising from it, may be referred to the conciliation in one of the conciliation organizations in the Republic of Croatia (Croatian Insurance Bureau, Croatian Chamber of Economy or Croatian Employers' Association).

(10) In addition, in the case of a dispute arising out of an insurance contract which is concluded online, complaints may be filed through the online dispute resolution platform (ORS Platform). The platform access link is available at www.allianz.hr

XXI. Jurisdiction in case of a dispute

Article 27

(1) If no peaceful solution to the dispute is reached despite the efforts to settle, the court disputes shall be under the jurisdiction of a competent court in Zagreb.

XXII. Applicable law

Article 28

(1) Applicable law is the law that the parties have chosen in accordance with Article 7 of Regulation (EC) No. 593/2008 of the European Parliament and of the Council of 17 June 2008. and Corrigendum to that Decree of 06.03.2013. In the case of non-selection of applicable law, applicable law will be the law of the state where the insurer has habitual residence / headquarter, except if a contract has more connections with another country (according to the circumstances), when the law of that other country will be applied.

(2) When the contractual party does not have the freedom of choice, Croatian law will be applied.

XXIII. Insurance Conditions application

Article 29

(1) The conditions shall apply to insurance contracts signed after December16th 2019.