General Terms and Conditions for Health Insurance for Foreigners (Welcome 230901)

Valid from 1.9.2023

SV. pojišťovna

Health insurance for foreigners

Insurance product information document

Company: SV pojišťovna, a.s., Czech Republic **Product: Welcome**

Full pre-contractual and contractual information about the product are provided in the General Insurance Terms and Conditions (GITC) for health insurance for foreigners Welcome 230901.

https://www.svpojistovna.cz/zdravotni-pojisteni-cizincu/welcome/

What type of insurance is this product?

The Welcome product has been designed for foreign nationals who stay permanently in the Czech Republic.

What is the subject of insurance?

- ✓ Insurance of medical expenses due to illness or injury.
- ✓ Costs related to repatriation

  The subject of insurance and limit of indemnity vary according to the tariff selected.
- ✓ Comprehensive health care – Complex, Prenatal, baby, Child+ tariffs - the limit of indemnity is EUR 400,000
- ✓ Urgent and emergency care –Standard and Plus tariffs – the limit of indemnity is EUR 60,000 – EUR 80,000
- ✓ Pregnancy, childbirth and newborn care –Baby tariff – the limit of indemnity is EUR 400,000, the limit of newborn care is CZK 300,000
- ✓ Pregnancy, childbirth – Prenatal tariff – the limit of indemnity is EUR 400,000

What is not covered?

- × Unless otherwise agreed in the insurance policy, the health insurance for foreigners does not cover the cases as per GITC Welcome 23091 Part I, Article 15.

Are there any limitations in the coverage?

- ! Persons with severe nervous disorders and mental disorders and such as disorders deafness, blindness, drug or alcohol addictions and diseases such as cancer, HIV, etc., cannot take out the insurance.
- ! The insurance does not cover the treatment of any diseases, injuries and other groups of diagnoses that existed before the inception of the insurance.
- ! The insurance does not cover the health care that is not covered for citizens of the Czech Republic who participate in the public health insurance in the sense of applicable legislation of general application.
- ! The insurance does not cover any costs of cosmetic treatment and its after-effects, chiropractic procedures or therapy.
- ! The insurance does not cover the preparation and adjustments of dentures, orthoses, glasses, contact lenses, hearing aids and similar devices.
- ! The insurance does not cover the termination of pregnancy unless the woman's life or health is endangered or the foetus is genetically defective, i.e. unless the termination of pregnancy is medically justifiable.
- ! The insurance does not cover the treatment of infertility or sterility and artificial insemination.
- ! The insurance does not cover medical procedures and its after-effects, if any, provided that the insured person has travelled to the Czech Republic or abroad to undergo the procedure.

Where am I covered?

✓ The insurance applies to insured events that have occurred in the territory of the Czech Republic and also during the trips to the Schengen Area countries from the Czech Republic.

What obligations do I have?

- The policy holder and the insured person are obliged to answer truthfully and completely all questions asked by the insurer when negotiating an insurance policy.
- The policy holder and the insured person are obliged to advise the insurer without any delay of any changes related to the insured person, insurance and changes of the insurance risk, i.e. for example, they are obliged to communicate to the insurer any changes of the residence, delivery address, or to inform the insurer of the termination of the insurable interest, etc.
- In the case of an insured event, the insured person, policyholder or entitled person are obliged to notify the insurer immediately of the occurrence of the insured event.
- Other obligations of the policyholder and the insured person are set out in GITC Welcome 230901 Part I, Article 17.

When and how to make payments?

Premium may be arranged as a single payment only, payable on the day of inception of insurance upon the entry into the insurance policy. The premium must be paid by the policyholder for the entire duration of cover in a single payment. If the premium is paid through a financial institution, bank or postal services provider, the premium shall be considered as paid on the day when the full amount is remitted to the insurer's respective account kept with a financial institution, or by payment of the full amount in cash to the insurer or a person authorised by the insurer to receive the premium. Premium paid without quoting a variable symbol or with an incorrect variable symbol quoted is understood as unpaid.

When does the insurance start and end?

The insurance starts and ends on the day and at the time specified in the insurance policy as the inception and termination of the insurance; for insurance policies arranged remotely, it is agreed that the above provision applies only provided that the first premium is paid before the agreed inception of cover and the insurance policy (offer) has been accepted by payment of the first premium by the policyholder to the extent proposed.

How do I terminate the insurance policy?

The insurance may be terminated by both parties as follows:
Within two months of the day of the entry into the insurance policy. An eight-day notice period begins to run on the day when the notice is delivered, and the insurance will lapse upon the expiry of the above notice period.
Without a reason being stated, within fourteen days of the day of the entry into the insurance policy or of the day when insurance terms and conditions were communicated, provided that the insurance policy was concluded in a form of a remote transaction or outside the insurer's business premises. In addition, insurance will lapse if the insurable interest no longer exists. The following cases are understood as the termination of insurable interests:

- participation in the public health insurance of the Czech Republic as per Act No. 48/1997 Coll., on the Public Health Insurance;
- a residence permit in the Czech Republic is not granted;
- the validity of a residence permit in the Czech Republic expires;
- the residence in the Czech Republic has terminated.

The insurer has a right to the premium until the insurer is advised of the termination of the insurable interest.
The fee for early termination of the policy amounts to 40% of the unused premium, and the insured person is obliged to return to the insurer all documents attesting to the validity of the insurance.
If the insurance terminates due to the insured person's death, the insurer is entitled to a lump-sum premium in full amount.
For further information on the termination of insurance see GITC Welcome 230901 Part I, Article 5.

Privacy notice

In this document, you will find information about the processing of your personal data and your rights in accordance with the General Data Protection Regulation 2016/679 (hereinafter as the "GDPR").

Who is responsible for the processing of your personal data (data controller)?

SV pojišťovna, a.s.
BB Centrum budova BETA
Vyskočilova 1481/4, 140 00 Prague 4

Tel +420 221 585 111
info@svpojistovna.cz

Our Data Protection Officer can be contacted at the above address or by e-mail at dpo@svpojistovna.cz.

What is the purpose of and the legal basis for the processing of your personal data?

We process your personal data in accordance with requirements of the EU GDPR, the Act on Personal Data Processing, the provisions of the Insurance Act with respect to personal data protection and other relevant legislation.

We need your personal data in order to assess the insurance risk and to conclude an insurance policy, to manage the insurance policy and related records, to send insurance certificates, or, as the case may be, to review insured events or to provide indemnity. All communications with us is monitored and retained, including calls with clients. It is impossible to enter into or manage insurance policies or to adjust insured events without personal data processing. In addition, we may process your personal data, for instance, in order to meet regulatory requirements, for insurance statistics or to create new tariffs.

In the case of pre-contractual negotiations or performance of contracts, your personal data is processed lawfully on the basis of Article 6(1)(b) of the GDPR. Where special categories of personal data must be processed, such as health data, we will ask for your pre-contractual consent as per Article 9(2)(a) of the GDPR and Article 7 of the GDPR. After the entry into an insurance policy, Article 9(2)(f) becomes the legal basis for the processing of health data.

We also process personal data for the purpose of protecting the legitimate interests of the SV insurance company or third parties (Article 6(1)(f) of the GDPR), which may be necessary for example:

- to arrange for IT operations and security thereof,
- for direct marketing of our own insurance products,
- for prevention and investigation, in particular if misuse of insurance is suspected.

Right to object

You have a right to object to the processing of your personal data for direct marketing as well as to the use for profiling in direct marketing. If we process personal data in order to protect legitimate interests, you may object to such processing of your personal data, including profiling, on the grounds of your particular situation. We further process personal data when fulfilling legal obligations, such as obligations to the Czech National Bank as a supervisory body or for the purpose of fulfilling tax or archiving obligations. The legal basis for such processing is the legal obligations set out in the applicable law as well as Article 6(1)(c) of the GDPR.

To what recipients do we forward your personal data?

Reinsurer

The insurance risks assumed by us are further insured by specialised insurance companies – termed as reinsurance companies. It may be necessary to forward insurance policies or information on insured events to the reinsurer to enable the reinsurer to obtain details of insurance cases and related risks.

Insurance intermediaries

If you take out insurance through an insurance intermediary, your personal data will be processed for the purpose of the entry into an insurance policy by the insurance intermediary, who will then forward the data to us. On the other hand, the insurance intermediary will receive from us your personal data to a necessary extent, if required for the insurance intermediary to be able to provide consultancy in a form of recommendations or advice and also for financial administration purposes.

Personal data processing in the insurance group of the SV insurance company

Within the SV insurance group, certain specific tasks are carried out centrally, such as data security backup or technical support for the information system of insurance management and adjustment, but at all times within the European Economic Area.

External service providers

To perform our contractual and legal obligations, we cooperate with selected external service providers, who may process personal data.
A list of those processors is available at svpojistovna.cz svpojistovna.cz/o-spolecnosti/ochrana-osobnich-udaju/, or at request.

Healthcare service providers

In concluding an insurance policy or in the case of an insured event, it may be necessary to require medical documentation from your physician or to require a medical report.

Financial institutions

If the indemnification payment is blocked in favour of another financial institution as per your insurance policy, that financial institution will be provided your personal data to a necessary extent.

Other recipients

We may be obliged to transfer your personal data to other recipients, e.g. the Czech National Bank, tax administrator or notaries.

What other sources of personal data do we use?

Data exchange between insurance companies

If, for instance, it is necessary to assess or supplement personal data regarding an insured or other relevant event, in relation to your insurance, information may be exchanged with other insurance companies to a necessary extent.

Data exchange with your employer

If your employer takes out insurance with you as an insured person, your personal data will also be provided.

How do we transfer personal data to third countries?

Any transfer of personal data outside the European Economic Area (EEA) by us happens only on the basis of decision of the Commission on the adequacy of the level of protection of personal data in that third country, or on the basis of the existence of other legal safeguards (e.g. standard contractual clauses or contracts between public authorities). In particular, the third countries where we transfer personal data during certain procedures include the USA. Details are available from the above-mentioned contacts.

Does automated decision-making/profiling take place?

On the basis of personal data, we make fully automated decisions, e.g. regarding the negotiation of insurance contracts or amounts of premium – especially when insurance is taken out online, which is important in accelerating the negotiation process. We also use profiling e.g. in direct marketing in the Internet environment, to ensure that we only approach you with an offer of insurance that is relevant to you, as well as in the performance of certain legal obligations, such as for the adoption of measures to prevent the laundering of the proceeds of crime and the financing of terrorism. Automated decisions are based on rules pre-defined by us – for example, insurance algorithms.

How long do we retain personal data?

We retain personal data for the duration of insurance policies or the investigation of insured events. Moreover, we retain personal data according to provisions of the Civil Code – the archiving period from the termination of insurance, or the settlement of an insurance claim may be as many as 17 years long. We also archive personal data for the purpose of fulfilling statutory archiving obligations, laid down chiefly in tax regulations, the Act on Accounting and Act on Certain Measures against the Legalization of Proceeds from Crime and the Financing of Terrorism.

What rights do you have?

In addition to the right to object, as mentioned above, you have a right to access your personal data and to obtain rectification of your personal data, the right to erasure and the right to restriction of processing, as well as the right to data portability. If you wish to access your personal data or to have your personal data rectified, please use the above contact data. Where the personal data processing is based on your consent, you have a right to withdraw your consent at any time.

How do I lodge a complaint about the processing of my personal data?

You can approach our Data Protection Officer at the e-mail address dpo@svpojistovna.cz or the Office for Personal Data Protection, at the address Pplk. Sochora 27, 170 00 Prague 7.

For the Privacy Notice go to svpojistovna.cz/o-spolecnosti/ochrana-osobnich-udaju/.

Information for prospective policyholders (prior to the entry into the insurance policy)

1. Insurer's data

A) Insurer's trade name and legal form
SV pojišťovna, a.s., Company ID No.: 618 58 714, operating insurance activities and activities related to insurance and reinsurance activities within the meaning of Act No. 277/2009 Coll., on Insurance Business, as amended.

B) Insurer's registered office address
Vyskočilova 1481/4, 140 00 Prague 4, Czech Republic

C) Registration in the Commercial Register
Commercial Register maintained by the Municipal Court in Prague, Section B, Insert 2740

D) Name and registered office of the authority in charge of supervision over the insurer's activities
Czech National Bank, Na Příkopě 28, 115 03 Prague 1

E) Contact data and manner of complaint handling
Telephone: +420 221 585 111
E-mail: info@svpojistovna.cz
E-mail: stiznosti@svpojistovna.cz
Web: www.svpojistovna.cz
By mail: to the insurer's registered office address
In person: at the insurer's registered office address, branch offices (for the list of branch offices go to www.svpojistovna.cz)
Complaints may also be lodged with the Czech Association of Insurance Companies or the Czech National Bank.
In the case of out-of-court resolution of consumer disputes, if any, and for life insurance, the competent authority is the Financial Arbitrator, Legerova 1581/69, 110 00 Prague 1, www.finarbitr.cz, or, for other insurance sectors, the competent authority is the Czech Trade Inspection Authority, Štěpánská 567/15, 120 00 Prague 2, www.coi.cz.

F) Language of communication between the parties
Czech language

G) Information regarding the insurer's solvency and financial standing
Available at www.svpojistovna.cz in the section About the company/Statutory information.

H) Contact data for the procedure of exercising a right to indemnification
By telephone: + 420 221 585 111
Web: www.svpojistovna.cz

2. Information on the obligation

A) Definition of health insurance for foreigners
The subject of the insurance consists in the demonstrable costs related to the insured person's stay in the Czech Republic (hereinafter as the "Czech Republic") or his/her trips to the other Schengen Area countries, which have incurred as part of the insured person's medical expenses due to his/her illness or injury, and costs related to his/her repatriation. This type of insurance, arranged by SV pojišťovna, a.s., is subject to Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter as the "CC"), other legislation of general application of the Czech Republic, General insurance Terms and Conditions for Health Insurance for Foreigners – WELCOME 230901 (hereinafter as the "GITC"), the insurance policy and other contractual arrangements, as applicable.

B) Persons who may become policyholders
Only natural persons residing in the Czech Republic or legal persons having their registered office or business branch in the Czech Republic to which the insurance applies, may take out the insurance as policyholders.

C) Non-insurable persons
Insurance cannot be taken out by the following persons:

a) persons with severe nervous disorders – including in particular impairments that entail severe physical limitations or limitations in daily life and work activities. These disorders include but are not limited to the stages of multiple sclerosis, amyotrophic lateral sclerosis (ALS), Morbus Parkinson, post-stroke condition with mobility limitations, epilepsy, new tissue formation (tumours) in the central nervous system, polyneuropathy with mobility limitations, severe brain or spinal cord injuries with mobility limitations, depression, attacks of unconsciousness and dizziness;
b) persons suffering from mental illnesses – in particular manic depressive psychoses, schizophrenic and paranoid disorders, Morbus Alzheimer and other forms of dementia, psycho-organic syndrome, Down's syndrome, hydrocephalus, autism;
c) persons suffering from the following diseases and limitations: deafness (bilateral), blindness (bilateral), paralysis, drug, alcohol and medication addiction, liver cirrhosis, cancer, malignant tumours (carcinoma), tuberculosis, kidney dialysis, HIV infection, AIDS.

D) Scope of cover and territorial scope
The insurance may be taken out in the scope of "complex health care", which is provided to the extent similar to public health insurance, but subject to the agreed upon exclusions from insurance and with limits of indemnity. Accordingly, the insurance does not include the coverage to the extent and in the amount in which payments would be made from the public health insurance, and it is not identical to sickness

insurance under Sections 2847 *et seq*. of the CC. Insurance may also be taken out in the scope of "necessary and urgent" health care. The territorial scope of insurance is further specified in Article 3 of the GITC.

E) Exclusions from insurance

Within the insurance, indemnity is not provided for: treatment of diseases, injuries and other groups of diagnoses that existed before the inception of the insurance; health care not paid to citizens of the Czech Republic who participate in the public health insurance in accordance with legislation of general application; health care that is provided to an insured person in a healthcare facility that does not normally provide that care to citizens of the Czech Republic who participate in the public health insurance in accordance with legislation of general application, except for acute life-threatening cases (e.g. in certain private clinics), and costs of medicines purchased by the insured person without prescription.

Further exclusions are specified in Article 15 of the GITC.

In the Welcome Complex tariff, pregnancy-related health care is subject to a waiting period of three months beginning from the inception of insurance, and pregnancy related care is subject to a waiting period of eight months from the inception of insurance, i.e. the insured person's pregnancy and related care that indisputably occurred before the end of the third month of the period of cover, or the childbirth that took place before the end of the eighth month of the period of cover as well as the subsequent postnatal care related to the childbirth do not constitute an insured event.

F) Duration of the insurance policy, insurance period

The insurance shall commence and end on the day and at the time specified in the insurance policy as the inception and end of the insurance, and for insurance policies arranged remotely, it is agreed that the above provision applies only provided that the first premium is paid before the agreed inception of cover and the insurance policy (offer) has been accepted by payment of the first premium by the policyholder to the extent proposed. Failing that, the insurance policy shall not be concluded. The insurance is arranged for a definite period and ends on the day and at the time specified as the end of insurance in the insurance policy. The insurance period is identical to the period of cover for which the insurance is arranged. The insurance cannot be taken out retrospectively.

The minimum duration of insurance is one month in the Welcome Standard and Welcome Plus tariffs, four months in the Welcome Complex tariff, and twelve months in the Welcome Baby and Welcome Child+ tariffs.

G) Methods of termination of the insurance, withdrawal from the insurance policy

The insurance shall be terminated by agreement between the insurer and the policyholder; by expiry of the period of cover; by termination of insurable interest; by termination of insurance peril; by the date of the insured person's death or on the day of the given legal person's dissolution without a legal successor, and/or by the policyholder's death or dissolution; by expiry of three months of the day of the entry into the insurance policy if the insured person's consent has not been proven, if such consent is required under legislation of general application; on the day when the insurer refuses to provide indemnity as per Article 5 of the GITC.

In addition, the insurance may be terminated by a notice of termination served by the insurer or policyholder. The policyholder or the insurer may terminate the insurance upon an eight-day notice period within two months of the day of the entry into the insurance policy or upon a one-month notice period within three months of the date of notification of an insured event. The policyholder may further terminate the insurance upon an eight-day notice period if the insurer has breached the principle of equal treatment for the determination of premium or for the calculation of indemnity; within one month of the date when the policyholder is delivered a notification of the transfer of the insurance portfolio or part thereof or the insurer's transformation; or within one month of the date when a notice is published that the insurer's licence to operate the insurance business has been revoked.

The insurance shall also be terminated by withdrawal from the insurance policy, with effect from the date of the conclusion of the insurance policy. The policyholder may withdraw from the insurance policy as follows:

a) without a reason being stated within fourteen days of the entry into the insurance policy or of the date on which the policyholder was informed of the insurance terms and conditions, provided that the insurance policy was concluded remotely or outside the insurer's business premises;
b) if the insurer or an agent authorised by the insurer, when arranging or amending the insurance policy, provides false or incomplete answers to the policyholder's written questions about the insurance deliberately or out of negligence. The policyholder may exercise this right within two months of the date on which the policyholder learnt such fact;
c) if the insurer must have been aware of the discrepancies between the insurance offered and the applicant's requirements when negotiating the insurance policy and the insurer failed to point out those discrepancies to the policyholder. The policyholder may exercise this right within two months of the date on which the policyholder learnt such fact. The insurer may withdraw from the insurance policy if the policyholder or the insured person, when arranging or amending the insurance policy, provides false or incomplete answers to the insurer's written questions about the insurance deliberately or out of negligence, and the insurer would not have concluded the insurance policy in the case of true and complete answers to the insurer's questions. The insurer may exercise this right within two months of the date on which the policyholder learnt such fact. The policyholder's act of withdrawal must be executed in writing and sent to the insurer's registered office address. The insurer is obliged, without undue delay and at the latest within one month of the day of delivery of a notice of withdrawal from the insurance policy, to return to the policyholder the premium paid, less any performance so far provided from the insurance by the insurer, and the policyholder, the insured person or the beneficiary, as the case may be, is obliged to return, within the same period, to the insurer the amount of the indemnity paid in excess of the premium paid. The right to withdraw from the insurance policy shall lapse if not exercised within the relevant period for the individual grounds for withdrawal as delineated above. The form for withdrawal from the insurance policy is available at www.svpojistovna.cz in the Client Service section or from the insurer's registered office or branch.

H) Information on the amount of premium and the limits of cover

Premium is understood as the payment for the insurance provided in the scope as agreed upon in the insurance policy. The amount of premium shall be determined by the insurer in accordance with the scope of insurance chosen by the prospective policyholder, to whom the amount of premium shall be communicated at all times prior to the entry into the insurance policy. The amount of premium depends on the tariff selected, the insured person's age and the scope of cover. Limits of cover are subject to the chosen scope of insurance cover, see the tables provided on the last pages of the GITC. In the premium for health insurance of foreigners, cost surcharges are calculated as 45% of the premium.

The limits of cover depend on the chosen scope of insurance cover, see the Informative overview of the scope of insurance.

I) Methods of payment and maturity of premium

Premium may be arranged as a single premium. The single premium is payable on the day of inception of insurance. The premium must be paid by the policyholder for the entire duration of cover in a single payment upon the entry into the insurance policy. If the premium is paid through a financial institution, bank or postal services provider, the premium shall be considered as paid on the day when the full amount is remitted to the insurer's respective account kept with a financial institution, or by payment of the full amount in cash to the insurer or a person authorised by the insurer to receive the premium. Premium paid without a variable symbol being quoted or with an incorrect variable symbol quoted is understood as unpaid.

I) Fees

The insurer shall not charge any extra fees for the use of remote communication means. The following charges shall be charged in excess of the premium:

Processing of the cancellation of insurance policy within 2 months of entry into the insurance policy	40% of unused premium
Issuing a duplicate insurance certificate / current status of the policy from the system	CZK 50
Issuing a photocopy of the draft / insurance policy from the external archive	CZK 100
Issuing a confirmation of premium payment (at request)	CZK 50
Termination of insurance in the event of cessation of insurable interest	40% of unused premium

K) Law applicable to the insurance policy, dispute resolution

All insurance policies concluded with SV pojišťovna, a.s., shall be governed by the legal order of the Czech Republic. Courts of the Czech Republic shall have jurisdiction over dispute resolution. At request, prospective policyholders may receive other information related to the health insurance for foreigners. In the case of an insurance policy concluded in a form of a remote transaction, the policyholder has a right to receive the insurance terms and conditions at any time during the term of the insurance policy.

L) Method of determining the amount of indemnity

The method of determining the amount of indemnity is loss-based or sum-based, depending on the specific cover, see the applicable Articles of the GITC.

M) Consequences of a breach of obligations from the insurance

The insurer draws attention to the provisions of Article 18 of the GITC regarding the consequences ensuing from a breach of obligations under the insurance policy.

General Terms and Conditions for Health Insurance for Foreigners – WELCOME 230901

Valid from 01 September 2023

Part I Introductory provisions

Health insurance for foreigners, arranged by SV pojišťovna, a.s. (hereinafter as the "Insurer") is subject to Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter as the "CC"), applicable provisions of Act No. 277/2009 Coll., on Insurance Business, as amended, these General insurance Terms and Conditions for Health Insurance for Foreigners – WELCOME 230901 (hereinafter as the "GITC"), which form an integral part of the insurance policy, and contractual arrangements, if any, which also form an integral part of the insurance contract. The insurance complies with requirements of Act No. 326/1999 Coll., on the Residence of Foreign Nationals, as amended.

Only natural persons residing in the Czech Republic or legal persons having their registered office or business branch in the Czech Republic to which the insurance applies, may take out the insurance as policyholders.

Article 1 Subject of insurance

1. The subject of insurance is the insured person's medical expenses incurred due to his/her illness or injury during his/her stay in the Czech Republic, unless otherwise specified.
2. The subject of insurance further includes costs related to the insured person's repatriation.
3. The insurance as per these GITC is arranged as loss insurance.

Article 2 Insured event

1. The insured event is understood as demonstrably incurred costs of the insured person's medical expenses during the period of cover, in the framework of the health insurance of foreigners.

Article 3 Territorial scope of insurance

1. The insurance shall apply to insured events that have occurred in the Czech Republic and also during trips from the Czech Republic to other Schengen Area countries. In the case of insurance in the Welcome Complex, Welcome Baby and Welcome Child+ tariffs, the cover is provided only to the extent of "necessary and urgent health care" according to the Welcome Plus tariff if the insured person travels from the Czech Republic to the other Schengen Area countries.
2. Unless otherwise provided in the insurance policy, the insurance shall not cover any insured events occurred:
   a) in the countries of which the insured person is a citizen;
   b) in the countries in which the insured person participates in the public health insurance or where the insured person is entitled to free health care;
   c) when the insured person travels from the Czech Republic to other Schengen Area countries in connection with work activities or other activities carried out for payment.

Article 4 Inception and duration of cover

1. The insurance shall commence on the date and at the time specified in the insurance policy as the inception of insurance; for insurance policies concluded remotely, it is agreed that the above provision applies only provided that the first premium is paid before the agreed inception of cover and the insurance policy (offer) has been accepted by payment of the first premium by the policyholder to the extent proposed. Failing that, the insurance policy shall not be concluded. The insurance cover shall be provided if both of the following conditions are met:
   a) the date and time of inception of the insurance specified in the insurance policy have occurred; and
   b) the premium has been paid in full.
2. The insurance is concluded for a definite period, the duration of insurance is limited to the number of days set out in the insurance policy. The insurance shall end on the date and at the time specified as the end of insurance in the insurance policy. If medical treatment continues to be provided after the end of insurance and the insured person is not eligible for repatriation, the Insurer shall provide insurance cover until the insured person becomes eligible for transportation, but no more than for four weeks (i.e. 28 days) of the end of insurance.

Article 5 Termination of insurance

1. The insurance may be terminated by agreement between the Insurer and the policyholder.
2. The insurance shall be terminated by expiry of the period of cover, unless otherwise agreed in the insurance policy.
3. The insurance shall be terminated if the insurable interest no longer exists. Typical instances of the cessation of insurable interest include the following:
   a) the insured person has been transferred to the public health insurance system,
   b) the insured person's application for visa has been declined, or the validity of a visa for residence in the territory of the Czech the Republic has expired,
   c) the stay in the territory of the Czech Republic has ended for reasons other than the refusal of a visa application or the expiry of a visa for stay in the territory of the Czech Republic.

   The Insurer has the right to the premium until the time when the Insurer became aware of the termination of the insurable interest. In connection with the termination of insurance, a fee of 40% of the unused premium shall be charged.
4. The insurance shall be terminated by expiry of a three-month period of the day of the entry into the insurance policy unless the insured person's consent has been proven, if such consent is required under legislation of general application.
5. The insurance shall be terminated on the day when the Insurer refuses to provide indemnity if the reason for the refusal was a fact:
   a) of which the Insurer became aware after the given insured event occurred;
   b) which the Insurer could not have discovered at the time when the insurance was negotiated, or the changes of which the Insurer could not have determined due to a culpable breach of the policyholder's breach of the obligation to provide true statements, and

c) the knowledge of which during the negotiation of the insurance policy would not make it possible for the Insurer to enter into this insurance policy, or the Insurer would have concluded the insurance policy under different terms and conditions.

6. The insurance may be terminated by either party:
   a) within two months of the entry into the insurance policy. An eight-day notice period shall begin to run on the day on which the notice is delivered, and the insurance shall cease on the lapse of the above period. In connection with the termination of the insurance, a fee of 40% of the unused premium shall be charged.
   b) within three months of the day when an insured event is notified. A one-month notice period shall begin to run on the day on which the notice is delivered, and the insurance shall cease on the lapse of the above period.
7. The insurance may be terminated by the policyholder with an eight-day notice period:
   a) within two months of the day when the policyholder discovered that the Insurer has breached the principle of equal treatment for the determination of premium or for the calculation of indemnity as defined in the CC;
   b) within one month of the day when the policyholder was advised of the transfer of the insurance portfolio or part thereof or the Insurer's transformation;
   c) within one month of the date when a notice is published that the insurer's licence to operate the insurance business has been revoked.
8. The Insurer may terminate the insurance:
   a) within one month of the day when the Insurer was notified of a change of the extent of the insurance risk as per Article 8(5) of the GITC, under the condition that the Insurer would not have concluded the insurance policy had such insurance risk existed at the time of the conclusion of the insurance policy. An eight-day notice period shall begin to run on the day on which the notice is delivered, and the insurance shall cease on the lapse of the above period.
   b) within two months of the day when the Insurer was notified of an increase in the insurance risk, provided that the Insurer has not been informed of the change by the policyholder or the insured person. The insurance shall be terminated on the day when the notice is delivered.
9. The policyholder may withdraw from the insurance policy:
   a) without a reason being stated within fourteen days of the entry into the insurance policy or of the date on which the policyholder was informed of the insurance terms and conditions, provided that the insurance policy was concluded remotely or outside the insurer's business premises;
   b) if the insurer or an agent authorised by the insurer, when arranging or amending the insurance policy, provides false or incomplete answers to the policyholder's written questions about the insurance deliberately or out of negligence. The policyholder may exercise this right within two months of the date on which the policyholder learnt such fact;
   c) if the insurer must have been aware of the discrepancies between the insurance offered and the applicant's requirements when negotiating the insurance policy and the insurer failed to point out those discrepancies to the policyholder. The policyholder may exercise this right within two months of the date on which the policyholder learnt such fact.
10. The Insurer may withdraw from the insurance policy if the policyholder or the insured person, when arranging or amending the insurance policy, provides false or incomplete answers to the insurer's written questions about the insurance deliberately or out of negligence, and the Insurer would not have concluded the insurance policy in the case of true and complete answers to the Insurer's questions. The Insurer may exercise this right within two months of the date on which the Insurer learnt such fact.
11. The policyholder's act of withdrawal must be executed in writing and sent to the insurer's registered office address. The insurer is obliged, without undue delay and at the latest within one month of the day of delivery of a notice of withdrawal from the insurance policy, to return to the policyholder the premium paid, less any performance so far provided from the insurance by the Insurer, and the policyholder, the insured person or the beneficiary, as the case may be, is obliged to return, within the same period, to the Insurer the amount of the indemnity paid in excess of the premium paid.
12. The right to withdraw from the insurance policy shall cease unless exercised within the prescribed period.
13. The insurance shall also be terminated upon the cessation of the insurance peril, the insured person's death or on the day when the legal person is dissolved without a legal successor, or upon the policyholder's death or dissolution as per Article 7(4) of the GITC.
14. In the case of termination or cancellation of the insurance, the Insurer shall be entitled to the insurance premium until the end of the period of cover.

Article 6 Insurable interest

1. The insurable interest constitutes a legitimate need for protection against the consequences of an insured event and establishes an essential condition for the formation and duration of insurance.
2. The policyholder shall have an insurable interest in his/her own life and health. The policyholder is also deemed to have an insurable interest in the life and health of a third person if he/she proves that the interest is conditional on his/her relationship to that person (i.e. kinship, conditional benefit or advantage from the continuation of that person's life, etc.).
3. The policyholder shall have an insurable interest in his/her own property. The policyholder is also deemed to have an insurable interest in the property of a third person if he/she proves that the policyholder would be at a risk of direct property damage without the existence and preservation of such property.
4. The policyholder's interest is considered as proven in the case that the policyholder has given consent to the insurance.
5. The insurance policy shall be null and void if the policyholder had not insurable interest and the Insurer knew or should have known this fact.
6. Where the policyholder knowingly insured a non-existent insurable interest, which was unknown or could not have been known to the Insurer, the insurance policy shall be null and void. In such case, the Insurer is entitled to remuneration corresponding to the premium until the time when the Insurer became aware of the nullity of the insurance policy.
7. If an insurable interest ceases to exist during the insurance, the insurance shall be terminated as well. In such case, the Insurer has a right to the premium until the time when the Insurer became aware of the cessation of the insurable interest.

Article 7 Insurance of other parties' insurance perils and the insurance for the benefit of third parties

1. If the policyholder concludes for his/her own benefit an insurance policy relating to an insurance peril as a possible cause of an insured event of a third party, the policyholder may exercise the right to indemnity if the policyholder proves that he/she has informed the third party of the contents of the insurance policy and that the third person, aware of the fact that he/she will not acquire the right to the

indemnity, agrees that the policyholder may accept the indemnity. Where the insured person is the policyholder's descendant who has not yet acquired full legal capacity, no special consent is required if the policyholder is the insured person's legal representative, and the subject of the insurance is not property.

2. Where consent of the insured person or his/her legal representative is required, and the policyholder fails to prove the consent within three months of the day of the entry into the insurance policy, the insurance shall be terminated by expiry of the above period. If an insured event occurs within that period and the insured person's consent has not been granted, the insured person shall acquire the right to the indemnity.
3. If the insurance policy is assigned by the policyholder without the consent of the insured person or his/her legal representative, the assignment of the insurance policy shall be disregarded. This provision shall not apply if the assignor is a person whose consent is not required for insuring the insured person's insurance peril.
4. On the day of the policyholder's death or the policyholder's dissolution without a legal successor, the insured person shall enter into the insurance; however, if the insured person notifies the Insurer in writing within thirty days of the day when the policyholder died or was dissolved that the insured person is not interested in the continuation of the insurance, the insurance shall be terminated on the day of the policyholder's death or dissolution. Effects of a delay against the insured period shall not arise until the expiry of fifteen days from the day on which the insured person became aware of his/her entry into the insurance.
5. If the insurance policy has been concluded for the benefit of a third party, that party may consent to the insurance policy also later when exercising the right to indemnity. The third party shall be entitled to indemnity if the insured person or his/her legal representative has given consent that the third party may accept the indemnity after having been informed of the contents of the insurance policy.
6. Where another party's insurance peril is insured for the benefit of a third party, the provisions of paragraphs 1 to 4 of this Article shall apply *mutatis mutandis*.

Article 8 Change of insurance risk

1. If circumstances that were delineated in the insurance policy or which the Insurer inquired about when arranging or amending the insurance policy change to such a substantial extent that the likelihood of an insured event arising from the expressly agreed upon insurance peril increases, the insurance risk shall increase.
2. Without the Insurer's consent, the policyholder must not conduct or allow any third parties to conduct any activities that might increase the insurance peril; where the policyholder discovers only later that without the Insurer's consent, the policyholder has caused the insurance peril to increase, the policyholder shall notify the Insurer without undue delay after the above fact comes to the policyholder's knowledge. If the insurance peril increases independently of the policyholder's will, the policyholder shall notify the Insurer without undue delay after becoming aware of the above fact. If another party's insurance risk has been insured, the aforesaid obligation pertains to the insured person.
3. In the case the Insurer concludes the insurance policy under different terms and conditions, if the insurance risk existed to an increased extent upon the execution of the insurance policy, the Insurer has a right to propose a new amount of premium. Unless the Insurer does so within one month of the day when the Insurer was notified of the change, the Insurer's right shall cease.
4. Unless the proposal for increasing the premium under para. 3 of this Article is accepted within one month of the day when the proposal is delivered or unless the newly determined premium is paid within one month of the day of delivery of that proposal, the Insurer has a right to terminate the insurance with an eight-day notice period. The above right of the Insurer shall expire if the Insurer fails to terminate the insurance within two months of the day when the Insurer received a notification of disagreement with the proposal for increasing the premium, or when the time-limit for the acceptance of the proposal expired.
5. Provided that the Insurer would not have concluded the insurance policy with respect to the terms and conditions valid at the time of conclusion of the insurance policy if the insurance risk had already existed to an increased extent when the insurance policy was concluded, the Insurer has a right to terminate the insurance with an eight-day notice period. The Insurer's right to terminate the insurance in the above manner shall cease if the Insurer fails to terminate the insurance within one month of the day when the change of the insurance risk was notified to the Insurer.
6. If the policyholder or the insured person breaches the obligation to notify an increase in the insurance risk, the Insurer has a right to terminate the insurance without notice. If the insurance is terminated by the Insurer, the Insurer has a right to the premium until the end of the insurance period during which the insurance was terminated; in such case, a single premium shall be payable in full to the Insurer. Unless the Insurer terminates the insurance within two months of the day when the increase in the insurance risk came to the Insurer's knowledge, the Insurer's right to terminate the insurance shall cease.
7. If the policyholder or the insured person breaches the obligation to notify an increase in the insurance risk and if an insured event occurs after the change, the Insurer is entitled to reduce the indemnity pro rata according to the proportion of the premium received by the Insurer to the premium that should have been received by the Insurer had the Insurer been notified of the increase in the insurance risk in time.
8. The provisions concerning the increase in the insurance risk shall not apply if the increase in the risk has been caused by avoidance or reduction of a higher damage, or due to an insured event or as a result of an act of humanity.

Article 9 Premium

1. The Insurer is entitled to premium for the duration of the insurance, unless otherwise agreed.
2. The policyholder is obliged to pay the premium in the amount determined.
3. Premium shall be paid in cash or to the account nominated by the Insurer, with a variable symbol being quoted, i.e. the number of the insurance policy. Premium paid without a variable symbol being quoted or with an incorrect variable symbol quoted is understood as unpaid.
4. The premium is agreed as a single premium.
5. The premium is payable on the day of inception of the insurance.
6. The premium shall be understood as paid:
   a) when paid by bank transfer, at the moment when the respective amount of the premium is credited to the Insurer's account under the correct variable symbol; however, for the payment of the first premium, the premium is considered to have been paid at the moment when the amount is debited from the account from which the premium is paid;
   b) when paid through the postal services provider, on the day when the payment is deposited at the post office;
   c) when paid in cash, on the day of payment to the Insurer's representative against a receipt issued.

7. The amount of the premium is dependent on the insured person's entry age, the tariff chosen and the length of insurance.
8. If an insured event has occurred as a result of which the insurance has been terminated, the Insurer is entitled to the premium until the end of the insurance period during which the insured event occurred; in such case, the single premium shall pertain to the Insurer for the entire period for which the insurance was arranged, unless otherwise agreed.

Article 10 Scope of cover

1. The insurance is arranged in the scope of "complex health care", which is provided to the extent similar to public health insurance, but subject to agreed exclusions from insurance and with limits of indemnity. Accordingly, the insurance does not include the coverage to the extent and in the amount in which payments would be made from the public health insurance, and it is not identical to sickness insurance under Sections 2847 *et seq*. of the CC.
2. The insurance covers the treatment of illnesses, injuries and other groups of diagnoses that have occurred after the inception of the insurance.
3. The insurance only applies to medial care provided by authorised healthcare providers.
4. The insurance covers:
   a) outpatient medical treatment;
   b) prescription medicines; medicines are considered not to include any auxiliary preparations, even if prescribed by physicians or if containing medical components, preventive medicines, cosmetic preparations and drugs;
   c) medical devices related to the insured person's treatment (plaster cast, bandage, crutches, etc.);
   d) physical therapy, if prescribed by a doctor, e.g. treatment by radiation, heat, etc.;
   e) diagnostic tests (X-ray, EEG, ECG, etc.);
   f) in the case of hospitalised treatment, standard placement in hospital in line with rules of the local statutory provisions, provided that the hospital is under constant medical supervision, has adequate therapeutic and diagnostic facilities, operates according to generally recognised scientific methods and keeps registers;
   g) costs of medically prescribed transport to the nearest suitable hospital or physician;
   h) urgent operations;
   i) costs of medicines purchased based on a prescription;
   j) follow-up examinations if the first treatment of the diagnosis concerned was paid by the Insurer;
   k) dental treatment due to an injury.
5. The insurance further covers:
   a) dispensary care related to the illnesses and injuries the cause of which occurred after the inception of the insurance;
   b) allergy-related treatment in the case of the first occurrence of the given type of allergy in the insured person, including any follow-up allergy or immunological examinations necessary; this, however, does not apply to medicines and all auxiliary preparations related to the given diagnosis;
   c) all medical care undergone by the insured person in connection with pregnancy and childbirth in the Czech Republic at the Insurer's contractual facility or another facility approved by the Insurer in advance. The above care is understood as all medical examinations undergone by the insured person during pregnancy, the childbirth, follow-up continuous postnatal hospitalisation and the first subsequent gynaecological examination during the puerperium after the discharge from maternity hospital;
   d) dental treatment for the purpose of pain relief, simple dental fillings and the necessary repairs of dentures, all up to the total amount of CZK 6,000.00 per insurance year for an individual insured person within all of his/her insurance policies.
6. The insurance further covers preventive care in the following scope:
   a) for children aged from 0 to 5 years, all preventive examinations by a general practitioner up to the maximum limit of CZK 3,000 per insurance year (provided that the insurance policy is concluded for a period of 12 months as a minimum);
   b) for children up to 18 years of age, a preventive examination by a general practitioner once in the insurance year;
   c) for adults, a preventive examination by a general practitioner once in two insurance years;
   d) for women aged 15 years or more, a preventive examination by a gynaecologist once during the insurance year;
   e) a preventive examination by a dentist once during the insurance year;
   f) compulsory vaccinations up to the maximum limit of CZK 1,000 per insurance year.
7. The Insurer shall provide indemnity for health care provided to the maximum extent of a claim of citizens of the Czech Republic who participate in the public health insurance within the meaning of valid legislation of general application.
8. If the insured person dies as a result of an injury or illness, the insurance covers reasonable and purpose-directed costs of:
   a) cremation in the place of death;
   b) repatriation, i.e. costs of a provisional coffin, embalming and transportation of remains in accordance with applicable legal regulations.
9. The total indemnity per insured event is limited to EUR 400,000. This amount constitutes a limit and must not be exceeded in the sum of the individual costs of health care, including repatriation, if any.

Article 11 Assistance services

1. An assistance service is understood as a service provided to the insured person in connection with the insurance arranged, and rendered by the Insurer's contractual partner.
2. The assistance service or another authorised foreign representative of the Insurer has a right to act on behalf of the Insurer in the event of any claims or loss events and to recommend or identify suitable healthcare facilities.
3. The assistance service shall provide help when the following is necessary:
   a) transportation, transfer, conveyance in the event of the insured person's illness or injury;
   b) transportation of the insured person's remains;
   c) provision of guarantee for the insurance cover and the settlement of costs for treatment by the Insurer.

Article 12 Waiting period

1. The waiting period shall only apply to the insurance taken out in the scope "complex health care". The waiting period shall begin to run on the day of inception of the insurance.

2. Health care related to pregnancy as per Article 10(5)(c) of the GITC is subject to a three-month waiting period, i.e. the insured person's pregnancy indisputably occurring before the expiry of the third month of the insurance period and the related care shall not constitute an insured event.
3. An eight-month waiting period shall apply to childbirth and the follow-up health care as per Article 10(5)(c) of the GITC, i.e. the childbirth that took place before the expiry of the eight month of the insurance period and the follow-up postnatal care related to the childbirth in question shall not constitute an insured event.
4. The waiting period under paras. 2 and 3 of this Article shall not apply to emergency treatment for life-threatening complications of pregnancy to the mother and child in the case of pregnancy complications, where the indemnity is paid according to the scope of "necessary and urgent health care".
5. The waiting period shall be waived if the insured person has concluded health insurance for foreigners with the Insurer for at least one year immediately preceding the inception of the insurance.

Article 13 Payment and maturity of indemnity

1. If an insured event occurs after the inception of insurance cover, the Insurer shall provide indemnity under the terms and conditions set out in the insurance policy. Indemnity is payable in the Czech Republic in the domestic currency and shall be provided to the insured person or the person entitled to the indemnity. The exchange rate officially announced by the Czech National Bank as of the day of occurrence of an insured event shall be used.
2. The upper limit of indemnity is determined by a sum insured and may be restricted by a limit of indemnity.
3. The Insurer shall complete the investigation and notify the entitled person of its results within three months of the day on which the loss event was reported to the Insurer. Unless the Insurer is able to complete the investigation within the aforementioned period, the Insurer shall inform the person who is to be or has been entitled to indemnity of the reasons why it is impossible to complete the investigation, and the Insurer shall provide the above person, at his/her request, with a reasonable advance payment, unless there exists a reasonable reason for the Insurer to refuse to do so. The aforementioned period shall not run if the investigation is prevented or hindered through the fault of the entitled person, policyholder or insured person. Indemnity shall be payable within 15 business days of the conclusion of the investigation necessary to determine the extent of the Insurer's obligation to provide the indemnity. The investigation is considered as having been completed when the Insurer informs the entitled person of its results.
4. The Insurer may postpone the payment of indemnity or an indemnity advance if:
   a) there is doubt as to whether the payment of the indemnity is justified, until the necessary documentation is submitted;
   b) criminal, administrative or other judicial proceedings have been initiated against the policyholder or insured person in connection with a loss event, until those proceedings are concluded.
5. Where indemnity or an indemnity advance has been paid without justification, the person to whom the indemnity has been paid is obliged to return it immediately, even after the insurance has ended.
6. If costs of the investigation expended by the Insurer have been caused or increased by a breach of an obligation by the policyholder, insured person or another person who exercises a right to the indemnity, the Insurer has a right to claim reasonable compensation from the person who has breached the obligation.
7. If, in connection with an insured event, the insured person incurs a claim against a third party for financial compensation which is the subject of this insurance, his/her right shall pass to the Insurer, up to the amount of the indemnity paid on the basis of the insurance policy. If the insured person waives the above right or claim without the Insurer's consent, the Insurer is not obliged to provide the indemnity up to the amount of the claim *vis-à-vis* the third party. If the indemnity has already been paid, the insured person is obliged to return the indemnity to the Insurer up to the amount of the claim *vis-à-vis* the third party.
8. If the insured person receives a payment from a third party who is obliged to provide the payment, the Insurer is entitled to reduce the indemnity accordingly. The insured person must notify the Insurer in this respect without undue delay.
9. If the insured person is entitled to reimbursement for health care of the public health insurance or a similar statutory system, the Insurer is obliged to provide the indemnity only in excess of the reimbursement from the public health insurance or a similar statutory system. The insured person may not waive such entitlement. Where the insured person does so, the Insurer has a right to reduce the indemnity accordingly by the amount corresponding to the amount of the entitlement.
10. Claims for indemnity may be assigned only subject tot the Insurer's prior written consent.

Article 14 Refusal and reduction of indemnity

1. The Insurer may refuse to provide the indemnity under the insurance policy if the insured event has been caused by a circumstance that came to the Insurer's knowledge only after the occurrence of the insured event and which could not have been discovered by the Insurer when concluding or amending the insurance as a consequence of intentionally or negligently false or incomplete answers to written questions, and if the Insurer would not have concluded the insurance policy had the Insurer known of the circumstance at the time of concluding the insurance policy or would have concluded the insurance policy under different terms and conditions.
2. The insurance shall be terminated on the day when a notification of refusal to provide the indemnity is delivered.
3. If, when concluding the insurance or amending the insurance policy, the policyholder or insured person violated any of the obligations set out in the insurance policy, and as a result, a lower premium was determined, the Insurer has a right to reduce the indemnity accordingly by the amount corresponding to the proportion of the premium received by the Insurer to the premium which should have been received by the Insurer.
4. Where a breach of obligations by the policyholder, insured person or another person entitled to indemnity has substantially affected the occurrence of an insured event, its development or has led to the increase in the extent of its consequences, or has substantially affected the identification or determination of the amount of indemnity, the Insurer may reduce the indemnity in proportion to the effect of such breach on the extent of the Insurer's obligation to provide indemnity. This provision shall also apply to if a breach of obligations has rendered it impossible to submit evidence that an insured event has occurred within the meaning of these GITC.
5. The Insurer is entitled to reduce the indemnity in the case above-standard medical care has been provided to the extent necessary and reasonable according to an opinion of a specialist physician authorised by the Insurer.

Article 15 Exclusions from the insurance

1. The insurance shall not cover:
   a) treatment of illnesses, injuries and other groups of diagnoses that existed before the inception of the insurance;

b) health care not paid to citizens of the Czech Republic who participate in the public health insurance in the sense of legislation of general application;
c) health care provided to the insured person provided in a healthcare facility which does not normally provide such care to citizens of the Czech Republic who participate in the public health insurance in the sense of legislation of general application (e.g. certain private clinics or other healthcare facilities whose services are not paid from the public health insurance), except for urgent life-threatening cases;
d) costs of medicines purchased by the insured person without a prescription;
e) costs of cosmetic treatment and its after-effects, chiropractic procedures or therapy;
f) preparation and adjustments of dentures, orthoses, glasses, contact lenses, hearing aids and similar devices;
g) termination of pregnancy unless the woman's life or health is endangered or the foetus is genetically defective, i.e. unless the termination of pregnancy is medically justifiable;
h) treatment of infertility or sterility and artificial insemination;
i) medical procedures and any after-effects, if the insured person has travelled to the Czech Republic or abroad to undergo the procedure;
j) costs of treatment carried out by the insured person's relative (e.g. husband, wife, parents);
k) spa and sanatorium treatment and rehabilitation arrangements;
l) costs of treatment incurred as a consequence of the application of treatment not recognised by medical professionals to be *lege artis*;
m) treatment of illnesses, injuries and their consequences which have been caused by war or participation in mass protests, civil disobedience events or other disturbance;
n) treatment of injuries caused while driving a motor vehicle without the appropriate authorisation (driving licence) if occurred outside the Czech Republic;
o) transportation, transfer or transport using an air ambulance unless the transportation has been approved by the assistance service in advance;
p) regulatory fees and additional payments;
q) treatment associated with the commission of a crime and disorderly conduct if occurring outside the Czech Republic;
r) treatment as a result of suicide or attempted suicide if occurring outside the Czech Republic;
s) intentionally caused illnesses or injuries if occurring outside the Czech Republic;
t) injuries caused under the influence of alcohol, drugs or other psychotropic substances if occurring outside the Czech Republic.

2. The Insurer shall not provide the indemnity if the insured person refuses to undergo repatriation, treatment or necessary medical examinations by the physician determined by the Insurer or a provider of the Insurer's assistance services.
3. The insurance does not cover any injuries caused during parachuting and paragliding, parachute jumps from heights, use of non-motorized aircraft, motorized hang gliders, ultralight aircraft, space shuttles, bungee-jumping, ballooning, hovercraft; furthermore, the insurance does not cover injuries occurring during the performance of duty by pilots, other crew members and persons who perform their official activities using aircraft; the insurance does not cover diving, including decompression, mountaineering, rock climbing, ice and waterfall climbing, rafting, canoeing on wild rivers, canyoning, ski mountaineering, skiing off marked routes, motocross and motor racing, karate, taekwondo, aikido, kung fu, judo, boxing, kick-boxing, etc.
4. The insurance does not cover sports activities of professional athletes. According to these GITC, a professional athlete is defined as an athlete who performs sports activities under a professional contract; an athlete who participates in competitions, races, tournaments or trainings or training camps at the level of the World Cup, Olympics, World Championships, Continental Championships or championships of individual countries.
5. The pursuit of activities mentioned in paras. 3 and 4 of this Article may be included in the insurance by a written agreement with the Insurer, or it may be added to insurance at a higher premium under terms and conditions as per the Insurer's insurance tariff.

Article 16 Non-insurable persons

1. The following persons are non-insurable and therefore not insured:
   a) persons with severe nervous disorders – including in particular impairments that entail severe physical limitations or limitations in daily life and work activities. These disorders include but are not limited to the stages of multiple sclerosis, amyotrophic lateral sclerosis (ALS), Morbus Parkinson, post-stroke condition with mobility limitations, epilepsy, new tissue formation (tumours) in the central nervous system, polyneuropathy with mobility limitations, severe brain or spinal cord injuries with mobility limitations, depression, attacks of unconsciousness and dizziness;
   b) persons suffering from mental illnesses – in particular manic depressive psychoses, schizophrenic and paranoid disorders, Morbus Alzheimer and other forms of dementia, psycho-organic syndrome, Down's syndrome, hydrocephalus, autism;
   c) persons suffering from the following diseases and limitations: deafness (bilateral), blindness (bilateral), paralysis, drug, alcohol and drug addiction, liver cirrhosis, cancer, malignant tumours (carcinoma), tuberculosis, kidney dialysis, HIV infection, AIDS.
2. Insurance shall not be established in the case of non-insurable persons.

Article 17 Obligations of the policyholder and insured person

1. Both the policyholder and the insured person are obliged to provide true and complete answers to all of the Insurer's questions when negotiating the conclusion or amendment of the insurance policy, as well as facts relevant to the Insurer's decision regarding the evaluation of the insurance risk, whether the Insurer shall insure the insurance risk and under what conditions, including questions about the insured person's health. In addition, the policyholder and the insured person are obliged to notify the Insurer without delay of any changes occurring during the term of insurance in the facts about which they were inquired when negotiating the conclusion or amendment of the insurance policy.
2. Both the policyholder and the insured person are obliged to communicate to the Insurer, in writing and without undue delay, any changes related to the insured person, the insurance and changes of insurance risks, in particular:
   a) changes of residence, or address for service;
   b) to notify the Insurer that either of them has taken out another insurance policy against the same insurance peril with another insurer; in doing so, they shall disclose the name of the Insurer and the amount of the sum insured;
   c) to notify the Insurer of the cessation of an insured interest and to evidence the same.

3. Both the policyholder and the insured person must adopt adequate measures to avert the occurrence of imminent damage, and take care to ensure that an insured event does not occur, in particular, they may not violate the obligations aimed at averting or mitigating the peril as set out in legislation of general application or the insurance policy.
4. In the case of occurrence of a loss event, the insured person, policyholder or entitled person have the following obligations:
   a) to notify the Insurer, without undue delay, that a loss event has occurred, provide a truthful explanation of the occurrence and extent of the event, submit all necessary original documentation, or, as appropriate, enable the Insurer to make copies using the original documentation, and proceed in the manner agreed upon in the insurance policy and in observance of the Insurer's instructions;
   b) to provide the Insurer, at the latter's request, with all information in writing as required for the determination of the extent of the Insurer's obligation to provide the indemnity. The required information may be submitted also to the Insurer's representative in a form of a written statement. Any costs of the preparation of the required documents shall be borne by the insured person or another entitled person. Documents forwarded to the Insurer shall pass to the Insurer's ownership and the Insurer is entitled to handle such documents;
   c) to authorise, at the Insurer's request, the Insurer's representative to request all data from third parties (including in particular physicians, hospitals, all types of healthcare facilities and insurance companies), and to act in relation to the loss event;
   d) to ensure that all reports and opinions required by the Insurer have been prepared and sent to the Insurer without undue delay;
   e) to prove to the Insurer the date commencement of the relevant trip abroad;
   f) to inform law enforcement authorities promptly of the occurrence of a loss event which has arisen under circumstances attesting to the commission of a crime or an attempted crime;
   g) to secure against another person a right to compensation for damage or loss or other similar rights and to exercise the claim for compensation for damage caused from the person liable for the damage;
   h) in the case of foreign language documents, to supply the Insurer with a certified translation to Czech, which documents shall be prepared at their own expenses;
   i) to submit original bills and accounting documents, which must state the name and surname of the person treated, indication of the diagnosis, details of the individual medical procedures, including costs of the treatment and all medical reports relating to the treatment concerned;
   j) to submit prescriptions which shall clearly show the name of the medicine prescribed, the price, the insured person's name and surname and the attending physician's stamp;
   k) for dental treatments, to submit a medical report to the Insurer, which shall specify the individual teeth treated and the description of the treatment provided.
5. To clarify the obligation to provide the indemnity, the Insurer may require additional necessary documentation and carry out any necessary investigation.

Article 18 Consequences of a breach of obligations

1. If, during the insurance negotiations, the policyholder or insured person has breached any of the obligations stipulated in the insurance policy or these GITC, and, as a result, a lower premium has been determined, the Insurer has a right to reduce the indemnity by the amount corresponding to the proportion of the premium received by the Insurer to the premium that should have been received by the Insurer.
2. If a breach of obligations of the policyholder, insured person or another person that is entitled to indemnity has had a substantial influence on the occurrence of an insured event, its development or has led to the increase of the extent of its consequences or has had a substantial influence on the identification or determination of the amount of indemnity, the Insurer may reduce the indemnity in proportion to the influence of such breach on the extent of the Insurer's obligation to provide indemnity. This provision shall also apply if a breach of obligations has rendered it impossible to submit evidence that an insured event has occurred within the meaning of these GITC.
3. The Insurer may withdraw from the insurance policy as per Article 5(10) of the GITC or to refuse to provide indemnity as per Article 14(1) of the GITC. The act of withdrawal from the insurance policy is also possible after an insured event occurs.
4. If a report on a loss event contains knowingly false or grossly misleading substantial information related to the extent of the loss event reported, or if information concerning the insured event is knowingly omitted from the report, the Insurer has a right to compensation for costs reasonably expended on the investigation of the facts about which the information was disclosed or omitted. The Insurer shall be considered to expend costs reasonably in the amount evidenced.

Article 19 Entitlement of the Insurer to ascertain and examine the details of the policyholder and insured person

1. The Insurer is entitled to ascertain and examine all necessary information about the policyholder and insured person in relation to the insurance. The policyholder and insured person are obliged to provide true and complete answers to all of the Insurer's written questions concerning the insurance to be taken out, amendments of the insurance policy or a loss event.
2. The Insurer may require information about the insured person's health condition and the determination of the insured person's health condition or the cause of his/her death. The process of determination of the health condition or the cause of death shall be carried out based on reports and medical documents required from attending physicians by the healthcare facilities authorised by the Insurer, and where necessary, also on the basis of a check-up or examination carried out by a healthcare facility.
3. By signing the insurance policy, the policyholder and insured person give their consent that the Insurer may ascertain information about the insured person's health condition and determine the health condition or the cause of death, if necessary for the type of insurance taken out, and they shall release physicians and employees of healthcare facilities, authorities and insurance companies where the policyholder and insured person have been, are and will be treated, recorded in registers or insured, from the obligation of non-disclosure, and they authorise the above parties to provide all necessary information to the Insurer.
4. Moreover, the Insurer is entitled to determine and examine the insured person's work and out of work activities (meaning sports or other hobby activities). The Insurer may also examine all answers provided by the policyholder and insured person to the Insurer's written questions.

Part II Final provisions

Article 20 Fees

Processing of the cancellation of insurance policy within 2 months of entry into the insurance	40% of unused premium
Termination of insurance in the event of cessation of insurable interest	40% of unused premium
Issuing a duplicate insurance certificate / current status of the policy from the system	CZK 50
Issuing a photocopy of the draft / insurance policy from the external archive	CZK 100
Issuing a confirmation of premium payment (at request)	CZK 50

Article 21 Legal acts, communication

1. All communications from the policyholder or insured person must be sent to the Insurer's address in writing. The Insurer's representatives are entitled to receive such communications; however, communications shall be deemed to have been delivered only when received by the Insurer.
2. The Insurer's notifications intended for the policyholder or insured person shall be delivered usually by a postal licence holder. Notifications may also by delivered by the Insurer's representative, to the address last known to the Insurer.
3. A letter sent through a postal services provider shall be deemed to have been delivered on the third business day after sending, or on the fifteenth business day after sending if sent to an address located in another state.
4. If the policyholder or insured person refused to receive the letter for no reason, the letter shall be deemed to have been delivered on the day when the policyholder or insured person refused to receive the same.
5. If the policyholder or insured person has not been reached and the Insurer's letter has been deposited by the letter carrier with the postal licence holder or the municipal authority having a local competence, the Insurer's letter shall be deemed to have been delivered on the last day of its storage period, even if the policyholder or insured person has not been informed that the letter was deposited.
6. If the policyholder or insured person fails to satisfy the obligation set out in Article 17(2)(a) of the GITC and has not notified the Insurer of their new address, the letter shall be deemed to have been delivered on the day when the non-deliverable letter is returned to the Insurer.

Article 22 Final provisions

1. Derogations in the insurance policy from these GITC are admissible if the purpose and nature of the insurance so require.
2. The Czech version of the GITC and contractual provisions are understood as authentic.
3. These GITC shall become valid and effective on 01 September 2023.
4. Should the insurance policy contain any legal defects due to changes of legislation of general application or otherwise, such legal defects shall not lead to the invalidity or ineffectiveness of the entire insurance policy. All provisions of the insurance policy shall be separable and if any provision of the insurance policy becomes invalid, illegal or contrary to the public interest, the validity of the remaining provisions shall not be affected thereby, and the insurance policy shall be treated as if the insurance policy had never contained such invalid provision. In the place of the invalid or ineffective provisions, the parties shall preplace such provisions with provisions the contents of which are capable of achieving the purpose of the insurance policy.
5. For out-of-court settlement of consumer disputes, if any, the competent authority in the case of life insurance is the Financial Arbitrator, Legerova 1581/69, 110 00 Prague 1, www.finarbitr.cz, and for other insurance types, the Czech Trade Inspection Authority, Štěpánská 567/15, 120 00 Praha 2, www.coi.cz.

Part III Definition of terms

Assistance service means a service provided to the insured person in connection with the insurance taken out and rendered by the Insurer's contractual partner.
Current premium means a premium for the insurance period agreed upon.
Waiting period means the period for which the Insurer has no obligation to provide indemnity for events that would otherwise constitute insured events.
Commuting means regular commuting of the insured person for the purpose of work outside the Czech Republic.
Single premium is a premium determined for the entire period for which the insurance has been taken out.
Fortuitous circumstance means a circumstance which is possible and for which it is uncertain whether it will occur at all during the insurance period or the time of which occurrence is unknown.
Beneficiary means a person who becomes entitled to indemnity as a result of an insured event in the case of the insured person's death.
Entitled person means a person who becomes entitled to indemnity as a result of an insured event.
Premium payer means a person who fulfils the obligation to pay premium or pro-rata part thereof based on agreement with the Insurer; this is without prejudice to the policyholder's obligation to pay premium.
Insurer is SV pojišťovna, a.s., Company ID No. 618 58 714, which is authorised to pursue insurance activities in accordance with a special law.
Certificate of insurance means a written document issued by the Insurer, which serves as a confirmation that an insurance policy has been concluded to the extent specified.
Sum insured means an amount agreed upon in the insurance policy, representing the maximum possible amount of indemnity payable by the Insurer if the conditions and circumstances laid down in the insurance policy are fulfilled.
Period of cover is the period for which the insurance has been agreed.
Insurance cover constitutes the total extent of cover agreed in the insurance policy.
Insured event is a fortuitous circumstance with which the Insurer's obligation to provide indemnity is associated as per provisions of the insurance policy.
Premium means the consideration for the insurance taken out.
Insurance peril means a possible cause of the occurrence of an insured event.
Period of cover is the period of time agreed in the insurance policy for which the current premium is paid.
Insurance risk is the degree of likelihood of the occurrence of an insured event caused by an insurance peril.
Policyholder is the person who has concluded the insurance policy with the Insurer and who is obliged to pay premium.
Insurance year is the period from the anniversary date of the inception of insurance to the next anniversary date of the inception of insurance.
Insurable interest is a justified need for protection against consequences of an insured event.
Insured person/the insured is the person whose life, health, property or liability or other values of insurable interests is covered by the insurance.
Insurance means an obligation between the Insurer and the policyholder, confirmed by an insurance policy, in which the Insurer undertakes to provide the policyholder or a third person with indemnity in the case of an insured event, and the policyholder undertakes to pay premium to the Insurer for the insurance cover provided.
Sum-based insurance is the insurance the purpose of which is to provide, in the case of an insured event, a lump sum or recurrent indemnity to the extent agreed upon, where the basis for determining the amount to the premium and for calculating the benefit is the amount specified in the insurance policy to be paid by the Insurer if an insured event occurs, or the amount and frequency of payment of pension.
Insurance against damage is the insurance the purpose of which is to compensate, to an extent agreed upon, for loss of property arising as a consequence of an insured event.
Repatriation means the medical transport of the insured person or remains to his/her home country, or another country where the insured person is permitted to reside.
Schengen area countries are Austria, Belgium, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Liechtenstein, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland.
Loss event is a circumstance based on which loss or damage has occurred and which could give rise to a right to indemnity.
Injury is an unexpected and sudden impact of external forces the Insurer's own physical forces independent of his/her will or an unexpected and uninterrupted impact of high or low temperatures, gases, vapours, electric currents and poisons (except for microbial poisons and immunotoxic substances) which has occurred during the insurance period and caused bodily injury to the insured person or death.
Anniversary date of insurance is the day which coincides with the date (day and month) specified in the insurance policy as the inception of insurance (also as the anniversary date of the inception of insurance). If there is no such day in the respective month, the anniversary date shall fall on the last day of the month.
Insurer's representative is a person authorised to act on behalf of the Insurer.

Contractual arrangements for health insurance for foreigners taken out in the Welcome Standard tariff

These contractual arrangements form an integral part of the insurance policy of health insurance for foreigners. The general principles of the health insurance for foreigners taken out with SV pojišťovna, a.s., are set forth in the General Insurance Terms and Conditions of Health Insurance for Foreigners – Welcome 230901 (hereinafter as the "GITC").

By way of derogation from Article 10(1) of the GITC, the insurance in the Welcome Standard tariff is arranged in the scope of "necessary and urgent health care", not in the scope of "complex health care".

1. By way of derogation from Article 10(9) of the GITC, it is agreed that the total indemnity per insured event is limited to EUR 60,000. This amount constitutes a limit and cannot be exceeded in the sum of the individual costs of health care, including repatriation, if any.
2. The insurance shall not cover any costs of treatment of diseases curable with over-the-counter medicines and devices.
3. The insurance shall not cover any costs of outpatient prescribed medicines.
4. By way of derogation from Article 10(4)(j) of the GITC, the insurance shall not cover follow-up examinations.
5. The insurance shall not cover the health care under Article 10(5) and (6) of the GITC, except for urgent treatment in life-threatening situations due to an allergic reaction in the case of the first occurrence of the given type of allergy occurs in the insured person.
6. The assistance services as per Article 11 of the GITC shall be provided to the insured person only if the costs of treatment of the insured person exceed CZK 5,000 or equivalent in a foreign currency. Where the costs of treatment of the insured person are lower than CZK 5,000 and, despite this, the insured person still decides to avail of assistance services, the insured person is obliged to compensate the Insurer for the costs incurred in connection with the provision of assistance services, but at least CZK 1,500. These costs may be deducted from the indemnity by the Insurer or the assistance service.

Contractual arrangements for health insurance for foreigners taken out in the Welcome Plus tariff

These contractual arrangements form an integral part of the insurance policy of health insurance for foreigners. The general principles of the health insurance for foreigners taken out with SV pojišťovna, a.s., are set forth in the General Insurance Terms and Conditions of Health Insurance for Foreigners – Welcome 230901 (hereinafter as the "GITC").

By way of derogation from Article 10(1) of the GITC, the insurance in the Welcome Standard tariff is arranged in the scope of "necessary and urgent health care", not in the scope of "complex health care".

1. The insurance shall not cover health care under Article 10(5)(a) of the GITC (dispensary care).
2. By way of derogation from Article 10(5)(b) of the GITC, the insurance shall not cover follow-up allergology or immunological examinations.
3. The insurance shall not cover health care under Article 10(5)(c) of the GITC (pregnancy), excepting necessary treatment in life-threatening situations of the mother or child in the case of pregnancy complications.
4. The insurance shall not cover health care under Article 10(5)(d) of the GITC (dental treatment, except for post-accident dental treatment), unless the insurance has been taken out for one-year period as a minimum.
5. The insurance shall not cover health care under Article 10(6) of the GITC (preventive care).

Contractual arrangements for health insurance for foreigners taken out in the Welcome Baby tariff

These contractual arrangements form an integral part of the insurance policy of health insurance for foreigners. The general principles of the health insurance for foreigners taken out with SV pojišťovna, a.s., are set forth in the General Insurance Terms and Conditions of Health Insurance for Foreigners – Welcome 230901 (hereinafter as the "GITC").
The insurance shall cover all medical care undergone by the insured person in connection with pregnancy and childbirth in the Czech Republic at the Insurer's contractual facility or another facility approved by the Insurer in advance. The above care is understood as all medical examinations undergone by the insured person during pregnancy, the childbirth, follow-up continuous postnatal hospitalisation and the first subsequent gynaecological examination during the puerperium after the discharge from maternity hospital.

The insurance is taken out in the scope of "complex health care" as per Article 10 of the GITC.

1. The waiting period for pregnancy under Article 12(2) of the GITC shall not apply to the insurance arranged in this tariff.
2. The waiting period for childbirth and the follow-up postnatal care under Article 12(3) of the GITC shall not apply to the insurance arranged in this tariff.
3. The scope of insurance under this tariff is extended to medical care of all children newly born to the insured person, up to one month of age, with a limit of indemnity of CZK 300,000. The above care is provided in the scope of "complex health care" and is understood as continuous postnatal hospitalisation, one preventive examination by the general practitioner after discharge from maternity hospital and compulsory vaccination up to the maximum limit of CZK 1,000.

Contractual arrangements for health insurance for foreigners taken out in the Welcome Child+ tariff

These contractual arrangements form an integral part of the insurance policy of health insurance for foreigners. The general principles of the health insurance for foreigners taken out with SV pojišťovna, a.s., are set forth in the General Insurance Terms and Conditions of Health Insurance for Foreigners – Welcome 230901 (hereinafter as the "GITC").

The insurance is taken out in the scope of "complex health care" as per Article 10 of the GITC.

1. By way of derogation from Article 10(6) of the GITC, the insurance covers all preventive examinations, including vaccination by general practitioner, and dentist, in the scope identical to the public health insurance of citizens of the Czech Republic.

Contractual arrangements for health insurance for foreigners taken out in the Prenatal tariff

These contractual arrangements form an integral part of the insurance policy of health insurance for foreigners. The general principles of the health insurance for foreigners taken out with SV pojišťovna, a.s., are set forth in the General Insurance Terms and Conditions of Health Insurance for Foreigners – Welcome 230901 (hereinafter as the "GITC").

The insurance shall cover all medical care undergone by the insured person in connection with pregnancy and childbirth in the Czech Republic at the Insurer's contractual facility or another facility approved by the Insurer in advance. The above care is understood as all medical examinations undergone by the insured person during pregnancy, the childbirth, follow-up continuous postnatal hospitalisation and the first subsequent gynaecological examination during the puerperium after the discharge from maternity hospital.

The insurance is taken out in the scope of "complex health care" as per Article 10 of the GITC, with limits as per the Welcome Complex tariff.

1. The waiting period for pregnancy under Article 12(2) of the GITC shall not apply to the insurance arranged in this tariff.
2. The waiting period for childbirth and the follow-up postnatal care under Article 12(3) of the GITC shall not apply to the insurance arranged in this tariff.
3. The scope of insurance under this tariff shall not cover medical care of the insured person's newly born children.
4. The minimum insurance period is 12 months.
5. The insurance covers insured events occurred in the Czech Republic and also during trips from the Czech Republic to other Schengen Area countries. During trips from the Czech Republic to other Schengen Area countries, only the insurance cover in the scope of "necessary and urgent healthcare" is provided according to the Welcome Plus tariff.

Informative overview of the scope of cover

Tarif Welcome	**Complex health insurance**				**Necessary and urgent care**	
	Complex	**Prenatal**	**Baby**	**Child +**	**Standard**	**Plus**
Total limit per insurance event	**EUR 400,000**	**EUR 400,000**	**EUR 400,000**	**EUR 400,000**	**EUR 60,000**	**EUR 80,000**
Schengen Area[7)]	**EUR 80,000**	**EUR 80,000**	**EUR 80,000**	**EUR 80,000**	**EUR 60,000**	**EUR 80,000**
Medical transportation	EUR 400,000	EUR 400,000	EUR 400,000	EUR 400,000	EUR 60,000	EUR 80,000
Repatriation of remains	EUR 80,000	EUR 80,000	EUR 80,000	EUR 80,000	EUR 60,000	EUR 80,000
Dental treatment – accident	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000
Other dental treatment	CZK 6,000	CZK 6,000	CZK 6,000	CZK 6,000	no	CZK 6,000
Outpatient prescribed medicines	yes	yes	yes	yes	no	yes
Treatment of illnesses curable with over-the-counter medicines	yes	yes	yes	yes	no	yes
Pregnancy, complications in pregnancy, childbirth	yes[1)]	yes	yes	no	no	no[2)]
Care of newborns	no	no	CZK 300,000	no	no	no
Assistance services	yes	yes	yes	yes	yes[3)]	yes
Preventive care, vaccination	yes[4)]	yes[6)]	yes[4)]	yes[5)]	no	no
Dispensary care	yes	yes	yes	yes	no	no

1) pregnancy and childbirth are subject to waiting periods of 3 and 8 months
2) this does not apply in acute life-threatening situations
3) only in the case of treatment the price of which exceeds CZK 5,000
4) up to the limit according to Article 10(6) of the GITC
5) to the same extent as public health insurance in the Czech Republic
6) insurance does not apply to Article 10(6)(a) and (b)
7) to the extent under Article 3(1) of the GITC