INSURANCE TERMS AND CONDITIONS FOR FOREIGNERS' COMPREHENSIVE HEALTHCARE MEDICAL INSURANCE
ZPCK 1/07
with effect as of 1 January 2007

Article 1
Introductory Regulations

1. The rights and responsibilities of parties to this **private** Foreigners' Comprehensive Healthcare Medical Insurance ("Insurance") are governed by the legal code of the Czech Republic, particularly the applicable provisions of Act No. 37/2004 Coll., on Insurance Policies, as subsequently amended, Act No. 40/1964 Coll., the Civil Code, as subsequently amended, Act No. 363/1999 Coll., on Insurance, as subsequently amended, these Insurance terms and conditions and other provisions set out in the Insurance Policy and its annexes and other documents which it comprises.
2. The contracting parties are on the one hand the Policyholder and on the other hand **Pojišťovna VZP, a.s.** , Jankovcova 1566/2b, 170 04 Prague 7, Czech Republic, IČ (Business Reg. No.) 27116913, registered in the Commercial Register held at Prague Municipal Court, Section B, Entry 9100 ("Insurer").

Article 2
Definition of Terms

1. The **Policyholder** is the party which has concluded an Insurance Policy with the Insurer.
2. The **Insured Person** is the party to whose health the Insurance relates.
3. The **Beneficiary** is the party which has a right to an Insurance Settlement as a result of an Insurance Event.
4. The **Insurance Certificate** is the written confirmation of the conclusion of the Insurance Policy, which the Insurer issues to the the Policyholder. The Certificate also serves as proof of payment of the single Insurance Premium.
5. The **Insured Person's Card** comprises written confirmation of the establishment of Insurance, which the Insurer issues for the requirements of the Insured Person; it is used to exercise the right to Insurance Benefits.
6. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to Insurance Benefits.
7. An **Insured Event** is an accidental state of affairs specified in Article 4, associated with the establishment of an obligation on the part of the Insurer to provide Insurance Benefits.
8. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one cause, comprising all the facts and their consequences, amongst which there is a causal, chronological or other direct connection.
9. The **Period of Validity of an Insurance Policy** is the period for which the validity of an entire Insurance Policy has been agreed.
10. The **Insurance Period** is the period for which the Insurance was agreed. This period is not reduced by the premature expiration of the Insurance.
11. The **Duration of Insurance** is the actual period of time for which the Insurance was in effect.
12. The **Insurance Term** is the period of time for which an insurance premium is paid. Unless it is agreed otherwise in the Insurance Policy, the Insurance Term is identical to the Insurance Period.

13. A **Single Insurance Premium** is the insurance premium determined for the entire period for which the Insurance has been agreed. The single Insurance Premium is always due to the Insurer as a total sum.
14. A **Return Insurance Premium** is an insurance premium paid for a period after the expiration of the Insurance.
15. An **Insured Risk** is the possible cause of an Insured Event.
16. An **Injury** is understood for the purpose of this Insurance to mean the unintended, sudden and unanticipated exertion of external forces or of the Insured Person's own physical strength, or the unexpected and uninterrupted effects of high or low external temperatures, gases, fumes, radiation, electric current or poisons (except for microbial toxins and immunotoxic substances), independent of the will of the Insured Person, resulting in damage to the health of the Insured Person or their death.
17. **Postnatal Care** is healthcare for a New-born Baby following immediately upon its birth and without interruption to the continuity of hospitalization, except in the case of exclusions detailed in Article 5.
18. A **New-born Baby** is understood for the purposes of this Insurance to be a child from the time of birth to three months of age.
19. The agreed Type of Insurance is set out in the Insurance Policy. The following types of Insurance may be taken out:

"Standard" – this Insurance does not apply to events for which Insurance Benefits are conditional upon taking out Insurance for Pregnancy or Professional Sports or Acute Stomatology.

"Pregnancy" – the restriction detailed in Article 4 paragraph 2c) does not apply,

"Professional sports" – the exclusion detailed in Article 5 paragraph 2 does not apply,

"Acute Stomatology" – the exclusion detailed in Article 5 paragraph 3 does not apply.

Article 3
Purpose and Subject of Insurance

1. It is agreed that the Insurance **covers losses**.
2. The purpose of the Insurance is to cover losses arising as a result of any Insured Event.
3. The subject of Insurance is the health of the Insured Person.

Article 4
Insured Events and the Extent and Due Payment of Insurance Benefits

1. An Insured Event consists in a loss affecting the Subject of Insurance during a stay in the Czech Republic by an Insured Person within the Duration of Insurance, arising from an Insured Risk involving:

- a change in the state of health of the Insured Person as a result of a sudden illness or Injury suffered by the Insured Person,
- other operations involving the state of health of the Insured Person, except in the case of exclusions detailed in Article 5.

2. Loss comprises necessary appropriate expenses demonstrably incurred on healthcare for the Insured Person in the Czech Republic throughout the Duration of Insurance provided in accordance with healthcare and legal regulations in effect, but only at healthcare facilities with which the Insurer has concluded an agreement with respect to this Insurance.

In the event of a sudden deterioration in the state of health of the Insured Person, when healthcare needs to be provided immediately or within a very short period, as delay

may otherwise result in serious damage to health or a threat to life, and if this healthcare is provided by a healthcare facility in the Czech Republic which has not concluded an agreement with the Insurer with regard to this Insurance, the Insurer shall defray all costs up to the amount of the cost of healthcare provided in a healthcare facility contracted to the Insurer, but only until such time as it is possible to transport the Insured Person to a healthcare facility contracted to the Insurer.
The Insurer shall provide Insurance Benefits to the following extent:
a) similar to those of public healthcare Insurance though with agreed exclusions from Insurance and with agreed Insurance Benefit limits; hence the Insurance does not provide compensation to the extent and the amount provided by Public Healthcare Insurance and so it is not identical to Sickness Insurance under Section 62 (3) of Act No. 37/2004 Coll., on Insurance;
b) repatriation of a sick Insured Person, which is necessary from a healthcare standpoint and carried out upon the assessment and approval of the Insurer's supervising doctor with the agreement of the attending physician and with the organisation of healthcare transportation designated by the Insurer's assistance service provider to the state of which the Insured Person is a passport holder or to another state in which the Insured Person is permitted residence. Upon prior approval, the Insurer may also cover the transportation costs of another person required to accompany the Insured Person in justified cases,
c) if the Insured Person is the mother of a New-born Baby within the Duration of the Insurance, the Insurer shall provide Insurance Benefits for cases of postnatal care for this New-born Baby, with the exclusions detailed in Article 5. This does not apply if the Insured Person was pregnant at the time an unassociated Insurance Policy was concluded while the "*Pregnancy*" type of Insurance was not agreed;
d) If the "*Acute Stomatology*" type of Insurance is agreed, i.e. if a non-zero limit is agreed for acute stomatology, the Insurer shall also provide Insurance Benefits to cover the costs of simple dental treatment (including extractions and fillings) by a dentist contracted to the Insurer to alleviate sudden pain within the scope of the Insurer's "Summary of Operations Covered" listing up to the maximum agreed limit detailed in the Insurance Policy;
e) If the Insurance Period has been agreed to be at least 12 months, the Insurer shall provide Insurance Benefits over and above the extent of damages in the case of healthcare costs for:
- preventive vaccination once a year to protect the Insured Person from flu,
- a supplement of up to CZK 300 for hormonal contraception for each Insured Person for the entire Duration of the Insurance Policy.
- if "acute stomatology" Insurance is agreed, partial compensation for a fixed orthodontic device corresponding to the application of dental retainers up to CZK 300 for each Insured Person for the entire Period of Validity of the Insurance Policy.

3. Costs detailed under paragraph 2 of this Article are paid directly for the Insured Person by the Insurer to the healthcare facility or to any other body or person that has demonstrably incurred such costs.

4. Direct defrayment of damages:
a) If the Insured Person has directly defrayed damages involved in an Insured Event, the Insurer shall subsequently settle appropriate costs upon presentation of originals of the required documents, see Article 11 paragraph 10), i.e. it will settle financial benefits.

Original documents remain with the Insurer and are not returned. If an original document has been submitted to a person other than the Insurer, a copy will suffice if it originally records and confirms payments made by this person.

b) If an Insured Person dies with an outstanding claim to financial benefits which they did not receive during their lifetime, the Insurer shall pay any person who demonstrably incurred the expenses. Otherwise the benefits are subject to inheritance proceedings.

c) Unless it is otherwise agreed in writing by the contracting parties, a financial settlement under this Article is payable on the territory and in the currency of the Czech Republic and the Insurer is to provide it by means of a transfer to the bank account of the Beneficiary or a postal order to the name and address of the Beneficiary.

d) The Insurer is to reduce the financial settlement from each prescription for out-patient medicines prescribed by a doctor by the deductible agreed in the Insurance Policy. The amount of the deductible is determined as a percentage of the Insurance Benefit and at the same time a minimum absolute sum in crowns. The amount of the financial settlement is understood to be the amount specified in the VZP ČR rates code-list for mass-produced medical products and individually prepared medical products designated MAX and in effect at the time the Insured Event took place.

5. For conversions from foreign currency, the Insurer is to use the exchange rate of the Czech National Bank in effect at the time the Insured Event took place.

6. If an Insured Event has taken place and continuous hospitalisation of the Insured Person exceeds the Duration of Insurance, the Insurer shall decide on the subsequent treatment procedure for the Insured Person as follows:

a) if the state of health of the Insured Person does not allow for their repatriation, they shall be treated in a healthcare facility designated by the Insurer until such time as their state of health improves to such an extent as to allow for repatriation to take place,

b) if the state of health of the Insured Person allows for repatriation, the Insurer will decide, with the assent of the examining doctor, on repatriation or completion of treatment in a healthcare facility designated by the Insurer outside the Czech Republic.

7. An upper limit applies to Insurance Benefits. The upper limit for Insurance Benefits is determined by the benefit limits specified in Paragraph 2 e) of this Article and the benefit limits specified in the Insurance Policy:

a) The overall benefit limit for expenses under Article 4 paragraph 2a) to 2d) (*overall limit of the Insured Person*) applies to Insurance Benefits for the sum of all that Insured Person's Insured Events occurring within the Duration of Insurance.

b) The individual limit detailed in item a) is the benefit limit for expenses under Article 4 paragraph 2a) (*total healthcare*), which defines the Insurance Benefits for a single Insured Event.

c) The individual limit detailed in item b) is the benefit limit for expenses under Article 4 paragraph 2b) (*repatriation*), which defines the Insurance Benefits for the sum of all Insured Events experienced by the Insured Person within the Duration of Insurance.

d) The individual limit detailed in item b) is the benefit limit for expenses under Article 4 paragraph 2c) (*care for a New-born Baby*), which defines the Insurance Benefits for the sum of all Insured Events experienced by the Insured Person within the Duration of Insurance.

e) The individual limit detailed in item b) is the benefit limit for expenses under Article 4 paragraph 2d) (*acute stomatology*), which defines the Insurance Benefits for the sum of all Insured Events experienced by the Insured Person within the Duration of Insurance.

8. The amount and extent of Insurance Benefits is determined by the Insurer in accordance with the Insurance terms and conditions.
9. If a Beneficiary has received compensation for incurred expenses from a third party or through another legal relationship, the Insurer is entitled to appropriately reduce the Insurance Benefits in view of the compensation which the Beneficiary has received. The Insurer may also reduce the Insurance Benefits in other cases laid down in Act No. 37/2004 Coll., on Insurance Policies, as amended.
10. The Insurer may refuse to provide Insurance Benefits if:
    a) the Insured Event was caused by a circumstance of which he was only apprised after such Insured Event took place and which he was unable to discover when the Insurance or an amendment thereto was agreed, due to neglectfully or intentionally incorrect or incomplete answers to written questions, if awareness of this circumstance at the time the Insurance Policy was concluded would have led him not to conclude the Insurance Policy or to conclude it under different terms and conditions,
    b) when exercising its rights to Insurance Benefits, the Beneficiary knowingly gave incorrect or grossly distorted information on the causes and extent of the Insured Event or withheld information of substantial importance on this Event.
11. Insurance Benefits are payable within 15 days of the end of investigations into a declared Event involving a claim for Insurance Benefits. The investigation ends as soon as the Insurer informs the Beneficiary of his results.

Article 5
Insurance Exclusions

1. Unless it is otherwise agreed in writing by the contracting parties, the Insurer shall not provide Insurance Benefits:

a) in the case of costs for:

- preventive healthcare at work,
- institutional care at specialist treatment centres,
- spa treatment,
- transplants,
- treatment for addiction, including all complications and associated diagnoses,
- treatment of AIDS and sexual diseases,
- healthcare for diabetes treated by insulin,
- treatment for chronic renal deficiency with haemodialysis or peritoneal dialysis,
- growth hormone treatment,
- treatment of haemophilia and other blood clotting disorders,
- treatment of congenital disorders and illnesses including their consequences, infertility and speech disorders,
- hearing aids, electric wheelchairs, myoelectric prostheses,

b) in other cases of examinations, checks and other healthcare procedures in the Insured Person's personal interests, which do not have a medical objective, including laboratory examinations (e.g. cosmetic healthcare procedures, artificial termination of pregnancy, infertility treatment, drafting of a medical confirmation at one's own request, a charge for requesting the services of an emergency pharmacy and so forth),

c) in cases of compensation for medicines and healthcare devices not prescribed by a doctor, i.e. on open sale without a medical prescription,

2. Unless the "***Professional Sports***" type of Insurance has been agreed, the Insurer will not provide Insurance Benefits for events occurring during the performance of and training for professional sporting activity. The Agreed Type of Insurance is specified in the Insurance Policy.

3. The Insurer will not provide Insurance Benefits for non-urgent stomatological treatment. Unless the "***Acute Stomatology***" type of Insurance has been agreed, the Insurer will not provide Insurance Benefits for urgent stomatological care either, except where this results from an Injury. The Agreed Type of Insurance is specified in the Insurance Policy.

4. The Insurer shall not provide Insurance Benefits:

a) for events which the Insured Person intentionally brought about themselves or which the Beneficiary intentionally brought about for the Insured Person,

b) for events which another person brought about for the Insured Person at the behest of the Insured Person or the Beneficiary,

c) for events whose cause or symptoms originated before the Insurance Policy was concluded or which must have been known to the Insured Person or the Policyholder before the Insurance Policy was concluded,

d) if the Insured Person refuses to undergo repatriation, treatment or the required medical examination by a doctor designated by the Insurer or the Insurer’s assistance service provider,

e) for events occurring during activities at locations not designated for such activities,

f) if a Loss Event occurs as a result of or in connection with:

- the effects of released nuclear energy, chemical or biological weapons,

- acts of war or civil war,

- acts of violence (including civil disorders and terrorist activities) in which the insured party has participated,

- the handling of a firearm or explosive by the Insured Person.

g) if a Loss Event took place as a result of or in connection with:

- disturbances or criminal activities committed or induced by the Insured Person,

- use by the Insured Person of alcohol, drugs, narcotics or other psychotropic or addictive substances or in connection with their effects,

Article 6
Conclusion of the Insurance Policy – Period of Validity of the Insurance Policy

1. The Insurance Policy is concluded upon acceptance of the Insurer's Insurance proposal, with both contracting parties signing the Insurance Policy within 60 days of the date on which the addressee received this proposal, but no more than 24 hours

before the proposed commencement of the Insurance Period. Should acceptance of this proposal involve additions, reservations, restrictions or other changes to the original proposal then this acceptance is deemed to be a new proposal. If the second party does not comment on the new proposal within the period of time designated for its acceptance then the proposal is deemed to have been rejected.

2. The Insurance Policy is concluded for a specific period of time from the agreed date of the commencement of validity of the Insurance Policy to the agreed date of termination of the validity of the Insurance Policy.
3. If the state of health of more than one person is the subject of Insurance, a list clearly designating all persons insured, the extent of the Insurance and the Insurance Period makes up an integral part of the Insurance Policy.
4. The Insurance Policy also comprises the Insurance terms and conditions, all agreements, a collaboration agreement, the supplements and annexes to the Insurance Policy and all documents defining the terms for the establishment, duration, alteration and expiration of the Insurance (e.g. applications, questionnaires, reports, medical examinations and checks and notices).
5. The initial medical examination report also makes up an integral part of the Insurance Policy. This initial medical examination must have taken place no more than 30 days before the date on which the initial medical examination report is presented to the agent. In the case of immediate follow-on policies, the initial medical examination must have taken place no more than three years before the date on which the insurance is agreed, unless the supervising doctor orders otherwise.

Article 7
Commencement and Duration of Insurance – Insurance Period

1. The Insurance is agreed for a fixed Insurance Period from the commencement of the Insurance Period to the end of the Insurance Period. The Insurance Period is agreed in the Insurance Policy.
2. The Insurance commences at 0.00 on the date agreed as that on which the Insurance Period commences.
3. The Insurance lasts from the agreed commencement of the Insurance Period to the actual expiration of the Insurance.

Article 8
Obligations of the Insurer

1. The obligation of the Insurer to provide Insurance Benefits arising from the Insurance Policy is subject to the occurrence of an Insured Event and the fulfilment of all conditions and obligations arising out of the Insurance Policy and parts thereof, particularly the payment of the Insurance Premium.
2. The Insurer is to provide assistance services, particularly when healthcare facilities are sought, or the validity of the Insurance Policy and the effectiveness of the Insurance are being verified, and to provide the required information on the agreed Insurance.
3. After conclusion of an Insurance Policy and payment of the Insurance Premium, the Insurer shall issue the Insurance Certificate to the Policyholder.
4. If a valid Insurance Certificate is lost, damaged or destroyed, the Insurer shall issue the Policyholder with a copy upon his request and at his expense. The Insurer may proceed likewise for an Insurance Policy or Insured Person's Card.
5. The Insurer shall supply information about the Insurer and the undertaking to those interested in Insurance before concluding the Insurance Policy through authorized Insurance agents.

6. Within the Duration of the Insurance Policy, the Insurer shall supply information to the Policyholder at his address as detailed in the Insurance Policy or via the Insurer's web pages. If the address for written communications is different from the registered office address or residential address then it is designated as the correspondence address. The address may also be an address designated for electronic communications.

Article 9
Obligations of the Policyholder

1. The Policyholder shall:
   a) pay the Insurance Premium to the Insurer,
   b) in a timely manner inform all Insured Persons, if different from the Policyholder, of the contents of the Insurance Policy, including all annexes and parts thereof, and provide them with all documents which he has received on their behalf from the Insurer,
   c) as soon as he learns of the commencement of multiple Insurance, inform the Insurer of its commencement, provide details of the other Insurers and the upper limit of the Insurance Benefits agreed in other Insurance Policies.
2. If the Insurance expires before the end of the agreed Insurance Period, the Policyholder shall always return the Insured Person's Card to the Insurer within five calendar days of the expiration of the Insurance. If the Policyholder is in delay with regard to this obligation the Insurer is entitled to require of the Policyholder a contractual fine of CZK 5,000 for each Insured Person's Card.
3. If the Policyholder is also the Insured Person, all the obligations of the Insured Person also apply to the Policyholder.

Article 10
Obligations of the Insured Person

1. The Insured Person shall:
   a) do everything to avert the occurrence of any Insured Event and to reduce the extent of damages arising,
   b) in a Loss Event, if his state of health permits, **always refer without delay to the Insurer's assistance services provider**, follow its instructions and upon request undergo a medical examination at a healthcare facility designated by the Insurer or by the Insurer's assistance service provider,
   c) if required to do so, seek medical treatment and produce the Insured Person's Card for the healthcare provider,
   d) at the request of the Insurer release the healthcare provider in writing from his obligation to maintain confidentiality and provide the Insurer with written authorization to obtain information which is subject to the obligation to maintain confidentiality from healthcare staff and which is required for the Insurer's investigation if any loss has occurred.
   e) to undergo treatment or necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider,
   f) if the state of health of the Insured Person permits and the healthcare treatment exceeds the Duration of the Insurance, to be repatriated at the request of the Insurer or of the Insurer's assistance service provider.
2. If immediate settlement is exceptionally required of the Insured Person by a healthcare facility for losses which constitute an Insured Event, the Insured Person shall:

a) take originals of the required documents, see Article 11 paragraph 10) and keep them securely until they are presented to the Insurer; the Insured Person also has this responsibility in other cases where losses are to be settled immediately,
b) pay the authorized recipient appropriate and demonstrable costs in cash,
c) without undue delay, present the required documents, see Article 11 paragraph 10) to the Insurer; the Insured Person also has this responsibility in other cases where losses are to be settled immediately.

Article 11
Other Rights and Responsibilities of the Parties to the Insurance

1. The Insurer is not obliged to investigate any excess in the Insurance, particularly if, for example, the settlement of the costs of healthcare for the Insured Person is effected by other means, e.g. if the Insured Person acquires permanent residence in the Czech Republic. These circumstances do not constitute grounds for the expiration of the Insurance or for the refund of the Insurance Premium or part thereof.
2. The Insurer is entitled to verify submitted documents, to call for expert reports and to consult with domestic and foreign healthcare facilities or other organizations and persons, even abroad.
3. The Policyholder and Insured Person shall:
   a) truthfully and comprehensively answer all questions asked by the Insurer regarding the agreed Insurance; this also applies where the Insurance is being amended or a Loss Event is being settled; the Insurer has the same obligation towards the Policyholder and the Insured Person,
   b) inform the Insurer in writing of any change to any information given in the Insurance Policy at any time within the Duration of the Insurance Policy,
   c) enable the Insurer to perform an investigation into the causes of a Loss Event and the extent of its consequences and to provide the Insurer with all required cooperation upon request,
   d) to inform the Insurer of all Insurance Policies effective at the time of the Loss Event, providing Insurance cover for the same risk.
4. The Beneficiary shall take measures to ensure that a right to compensation for damage which is assigned to the Insurer under the law does not lapse or expire.
5. The Beneficiary must not conclude any agreements with third parties relinquishing his claim to compensation with regard to such a third party if any such claims are assigned to the Insurer.
6. The Beneficiary shall confirm the assignment of a claim in writing at the request of the Insurer.
7. If the Insured Person dies, all their obligations apply to the Beneficiary.
8. A legal representative shall act for persons who are not competent to perform legal acts.
9. The Policyholder shall notify the Insurer in writing without undue delay of any event associated with a requirement for Insurance Benefits. This notification is deemed to be accepted when:
   a) the Policyholder notifies the Insurer on a correctly completed form from the Insurer that a Loss Event has occurred and presented a truthful explanation of the occurrence and extent of the consequences of this event,
   b) the Policyholder has presented the Insurer with originals of the required documents.
   If the Policyholder is not at the same time the Insured Person then it is the Insured Person who has these obligations. These obligations may also be fulfilled by another person or entity (e.g. a healthcare facility).

10. Required documents include:

A) original documents demonstrating:

a) the cause, time, place and circumstances of the occurrence of an Insured Event, its extent and the direct connection of the Insured Event with the Insured Person, at least detailing the first name, surname and date of birth of the Insured Person,

b) a detailed specification of the subject of compensation (e.g. a medical report with the description, code and date of measures taken, the diagnosis number and name and quantity of medicines),

c) confirmation of payment (bills made out by a doctor or pharmacist on the basis of the prescription of the attending doctor) detailing the amount and the subject of payment,

B) in the case of Insurance Benefits for out-patient medicines and healthcare aids prescribed by a doctor, also originals or copies of the prescription made out to the name of the Insured Person, detailing the date of issue, the quantity and description of the medicines and healthcare aids, and the signature and stamp of the issuer.

C) for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,

D) for the death of the Insured Person, also an official death certificate and medical certification of the cause of the death.

All documents must be made out for the Insured Person and have a date of issue, the signature and the stamp of the issuer.

Article 12
Insurance Premium

1. The Insurance Premium is the payment to be made for the Insurance cover provided. The amount of the Insurance Premium is determined by the Insurer.
2. Any change in Insurance risk within the duration of the Insurance is reflected in the amount of the Insurance Premium.
3. This is Insurance with a single Insurance Premium. Unless the contracting parties agree otherwise in writing, the single Insurance Premium is payable in full in the currency of the Czech Republic on the date the Insurance Policy is concluded.
4. The Insurer has the right to the Insurance Premium for the entire Insurance Period, even if the Insurance expires before the lapse of the Insurance Period. The Insurer acquires this right on the date the Insurance Policy is concluded.
5. If the Insurance Policy is terminated **by agreement** before the date of commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with taking out and administering the Insurance, upon the return of all documents confirming the validity of the Insurance.
6. If the Insurance expires **upon the notice of the Insurer** and if the Policyholder, Insured Person and any other Beneficiary have not breached the obligations of parties to private Insurance, the Insurer shall send back the unearned part of all received premiums to the Policyholder, upon the return of all documents confirming the validity of the Insurance and after all claims to Insurance Benefits have been ascertained, minus the amount of Insurance Benefits paid from this Insurance Policy.

Article 13
Amendments to the Insurance Policy, Expiration of the Insurance and Termination of the Insurance Policy

1. All amendments to the Insurance Policy are made in writing upon the mutual agreement of the contracting parties.
2. The termination of the Insurance Policy by the Policyholder is conditional upon presentation of a written declaration from the foreigners police to the Insurer to the effect that the Insured Person does not have the obligations of a foreigner upon entry to the Czech Republic or when staying on its territory, relating to the presentation of proof of the provision of compensation for healthcare costs or proof that travellers healthcare Insurance has been taken out to the extent laid down in Act No. 326/1999 Coll. on the Residence of Foreigners on the Territory of the Czech Republic, as amended.
3. The Insurance Policy expires upon the lapse of the Insurance Period at 24.00 of the date agreed as the date of termination of the Insurance.
4. The Insurance expires on the date of the decease of the Insured Person.
5. The Insurance expires on the date notification from the Insurer is delivered on the refusal of Insurance Benefits.
6. If when arranging for an Insurance Policy, a Policyholder or Insured Person are responsible for incorrectly or incompletely answering the Insurer's written questions on the private Insurance to be arranged, whether by intention or by neglect, the Insurer has the right to withdraw from the Insurance Policy, if correct and complete answers to the questions would have meant he would not have entered into the policy. The Insurer may exercise this right within two months of the date on which he ascertained such circumstances, otherwise the right expires. This also applies to amendments to an Insurance Policy. The Policyholder has the same right to withdraw from an Insurance Policy under the same conditions as the Insurer, if the Insurer or an authorized representative incorrectly or incompletely answers written questions on the private Insurance to be arranged. Withdrawal from the Insurance Policy means it is annulled from the outset. Without undue delay and within a period of 30 days of the date of withdrawal from the Insurance Policy, the Insurer shall return Insurance Premiums paid in, minus any Benefits which have already been paid out. If the Insurer withdraws, the costs associated with the establishment and the administration of the Insurance are deducted. A Policyholder, or an Insured Person who is not at the same time a Policyholder, is to return to the Insurer within the same period of time as the Insurer any amount paid as an Insurance Benefit exceeding the amount of Insurance Premiums paid in.
7. Upon expiration of the Insurance, the Insurance Policy terminates.
8. In exceptional cases the Insurance Policy may be terminated by the written agreement of the contracting parties under agreed conditions.

Article 14
Assignment of a Claim to the Insurer

1. If a Beneficiary has been provided with a Benefit for an Insured Event for which the Insurer has a claim to compensation for damage relating to a third party then this claim is assigned to the Insurer up to the amount which the Insurer provided.
2. If in connection with the exercise of a claim the Insurer incurs further costs due to the Beneficiary, the Insurer is entitled to require the Beneficiary to pay these costs.

Article 15
Delivery of Documents

1. The Insurer's documents designated for parties to the Insurance ("Addressees") are to be delivered by the holder of a postal licence ("Post Office"), by ordinary or registered mail to the correspondence address given in the Insurance Policy or annexes or detailed in documents presented to the Insurer. If the correspondence address of the Addressee is not given, the Insurer shall use the address of his registered office or permanent residence. Documents may also be delivered by one of the Insurer's employees or by another person authorized by the Insurer; in these cases the document is deemed to be delivered on the date it is accepted.
2. A document sent by registered mail to an Addressee is deemed to be delivered on the tenth day following dispatch of the consignment. A document from the Insurer sent to an Addressee by registered mail with a delivery slip is deemed to be delivered to the Addressee detailed on the delivery slip. A consignment delivered to a recipient different from the Addressee, to whom the Post Office presented the consignment in accordance with legal regulations on postal services, is deemed to be delivered to the Addressee.
3. If an Addressee refuses to accept a document upon delivery, the document is deemed to be delivered on the date on which its acceptance was refused by the Addressee.
4. If an Addressee has not been found and a document sent by registered mail or registered mail with a delivery slip has been deposited at the Post Office and the Addressee has not collected the document within the period of deposit (determined by legal regulations on postal services), the document is deemed to have been delivered on the last day of the period of deposit, even if the Addressee did not find out about the deposit or was not at the place of delivery.
5. If a document is returned undelivered for other reasons than those given in the previous paragraph, the document is deemed to be delivered on the date of its return to the Insurer.
6. The provisions of the Civil Court Code are applied in a corroborative manner for other cases of delivery not regulated under this Article.

Article 16
Assistance Service

The assistance service is the service provided to the Insured Person in association with the agreed Insurance and it is secured by an organisation contracted to the Insurer. The assistance service is provided 24 hours a day all year round. Contact details for the assistance service provider are given on the Insured Person's Card.

Article 17
Rescue Costs

With the exception of costs incurred in saving the life or the health of individuals, the amount of compensation for rescue costs for the period of validity of the Insurance Policy is limited to the sum of CZK 100,000.

Article 18
Joint Provisions

1. The Insurance terms and conditions make up an integral part of the Insurance Policy.
2. Declarations and statements to the Insurer are only valid if they are submitted in writing.
3. The language of communication is Czech.

4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.
5. The Insurer’s ordinary costs associated with taking out and administering the Insurance come to 20% of the Return Insurance Premium.
6. Insurer's costs for issuing copies come to CZK 50 for each document.
7. All disputes arising out of or in connection with this Insurance which are not resolved by agreement or out-of-court settlement shall be dealt with by any court having jurisdiction in the Czech Republic in compliance with Czech law.