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

Article 1
Introductory Regulations

1. The rights and duties of parties to **private** health Insurance for foreigners in the event of emergency treatment ("Insurance") shall conform to the legislation of the Czech Republic. The appropriate regulations of Act 37/2004 Coll., on Insurance Policies, as amended, the Civil Code Act 40/1964 Coll., as amended, and Act 363/1999 Coll., on Insurance, as amended, as well as these Insurance terms and conditions and other regulations detailed in the Insurance Policy and the appendices thereto and other documents forming a part thereof, shall apply in particular to this Insurance.
2. The contracting parties are the Policyholder as the first party, and **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 the Prague Municipal Court, Section B, File 9100 (the "Insurer") as the second party.

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** comprises written confirmation that an Insurance Policy has been concluded, which the Insurer issues to the Policyholder. The Certificate also serves as proof of payment of the single Insurance Premium.
5. The **Insured Person's Card** is written confirmation from the Insurer of the establishment of Insurance. The Insurer issues it to the Insured Person and 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. **Sudden Illness** is understood to mean any sudden and unexpected health disorder which directly threatens the health or the life of the Insured Person, irrespective of their own will, and which requires Urgent and Necessary Healthcare.
17. **Necessary Healthcare** is understood to mean the treatment, diagnosis and cure of sudden (acute) states when healthcare needs to be provided immediately or within a very short period.
18. **Urgent Healthcare** is understood to mean the treatment, diagnosis and cure of sudden (acute) states involving the possibility that basic life functions and associated states may be affected and where any delay may result in serious damage to health or a threat to life.
19. An **Injury** is understood for the purpose of this Insurance to mean the sudden and unexpected exertion of external forces or of the Insured Person's own 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.
20. A **Stay** refers to a tourist or business (depending on the Type of Insurance agreed on) trip and the Stay of the Insured Person.
21. The **Insurance Location** refers to the territory specified in the Insurance Policy under the agreed kind of **territorial validity**. If the Insurance has the territorial validity of:
    - "**Czech Republic**" (also designated "**CZ**"), the Insurance Location is deemed to be the territory of the Czech Republic.
    - "**Czech Republic and transit countries**" (also designated "**CT**"), the Insurance Location is deemed to be the territory of the Czech Republic and the Route through Transit States, with the exception of the State of Origin.
22. The **Route through Transit States** is understood to mean a journey taken exclusively for purposes of travel from the State of Origin to the Czech Republic and back.
23. **Transit States** are only understood to be those states which have to be crossed for the fastest and shortest transportation of the Insured Person from the State of Origin to the Czech Republic and back.
24. The **State of Origin** is understood to be the state where the Insured Person is a citizen or the state in which the Insured Person has long-term residence.
25. The agreed **Type of Insurance** is set out in the Insurance Policy. If the following Type of Insurance is agreed:

    Tourist Stay (also designated "**TP**") – this Insurance does not apply to events occurring as a result of the performance of work or employment,

    Working Stay (also designated "**PP**") – the exclusion for a Working Stay detailed in Article 5 paragraph 1v) does not apply

    Sports Competitions (also designated **S1**) – the exclusion for sports competitions detailed in Article 5 paragraph 1t) does not apply,

    Dangerous Sports (also designated **S2**) – the exclusion for dangerous sports detailed in Article 5 paragraph 1t) does not apply, nor does the exclusion for sports competitions detailed in Article 5 paragraph 1u),

Out-patient Medicines (also designated "**AL**") – the exclusion for Out-patient Medicines prescribed by a doctor detailed in Article 5 paragraph 1y) 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. Apart from the exemptions detailed in Article 5, an Insured Event consists in a loss affecting the Subject of Insurance arising during a Stay Abroad within the Duration of Insurance from an insured risk involving a change in the state of health of the Insured Person as a result of a Sudden Illness or the results of an Injury, which requires the provision of Urgent and Necessary Healthcare.
2. Loss comprises necessary expenses demonstrably incurred on healthcare for the Insured Person at the Insurance Location and within the duration of Insurance to the following extent:
   a) Urgent and Necessary Healthcare including
   - necessary examinations required to establish the diagnosis and treatment procedure,
   - necessary treatment,
   - necessary hospitalisation of the sick person in a multi-bed ward with standard facilities,
   - necessary operations with associated essential expenses,
   - transportation necessary from a healthcare standpoint from the location where the Insured Event took place to the nearest medical first aid facility or hospital and back,

   b) repatriation of the sick Insured Person if required by healthcare considerations, performed 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,
   c) transportation of the remains of the Insured Person to the state of which he is a passport holder or to another state where the Insured Person was permitted residence, performed by a specialist organisation approved by the Insurer or the Insurer's assistance service provider.
   d) urgent dental treatment on the Insured Person (including extractions and fillings) to alleviate sudden pain except in the case of the preparation and repair of prostheses (orthopedic or dental) and fixed bridges,
   e) medicines prescribed by an out-patient doctor to the name of the Insured Person, if a non-zero limit is agreed for prescribed Out-patient Medicines,
3. Costs detailed under paragraph 2 of this Article are paid 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 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.

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

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 hospital designated by the Insurer until such time as their state of health improves to such an extent as allows 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 hospital designated by the Insurer.

7. Insurance Benefits have an upper limit. The upper limit for Insurance Benefits is determined by the Benefit limits specified in the Insurance Policy.
   a) The overall benefit limit for expenses under Article 4 paragraph 2a) to 2e) (*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 applies to 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) and c) (*repatriation and transportation*), which applies to 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 2d) (*dental treatment*), which applies to 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 e) is the benefit limit for expenses under Article 4 paragraph 2e) (*prescribed out-patient medicines*), which applies to 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 it was only apprised after such Insured Event took place and which it 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 an awareness of this circumstance at the time would have led it not to conclude this agreement 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 for the following cases:
    a) birth including premature birth and confinement, abortion, artificial insemination, infertility testing and treatment or examinations (including laboratory and ultrasound) to ascertain and monitor pregnancy, examinations associated with contraception and reimbursement for contraception,
    b) dental treatment and associated services, except in the case of the results of an Injury or essential simple dental treatment to eliminate sudden pain,
    c) the examination and treatment of psychiatric disorders not associated with any other Sudden Illness or Injury, psychiatric testing and psychotherapy,
    d) operations not provided by a healthcare facility or healthcare workers, or treatments and therapies which are not medically recognised,
    e) preventive checks, vaccinations, medical checks, treatment and medicines not directly associated with Sudden Illness or Injury,
    f) cosmetic measures,
    g) rehabilitation, physical treatments, spa cures or healthcare in specialist treatment centres, chiropractic operations, training therapy or self-sufficiency training,
    h) acupuncture and homeopathy,
    i) organ transplants, haemophilia treatment, insulin therapy, except for the provision of first aid, chronic haemodialysis and the administration of medicines just launched in the Insured Person's State of Origin,
    j) complications which may occur during the treatment of illnesses or Injuries to which the Insurance does not apply,

k) sexual diseases and AIDS (including its complications) and treatment for HIV positivity,
l) spectacles, contact lenses and hearing aids,
m) suicide committed or attempted by the Insured Person,
n) situations in which the Insured Person failed to observe legal provisions in effect in the state where they are staying, e.g. driving a motor vehicle without a valid driving licence at the time the loss occurred,
o) events associated with disturbances incited by the Insured Person or with criminal activity committed or attempted by the Insured Person,
p) events occurring during preparations for and performance of professional sporting activity,
q) events occurring during trial tests of means of transport,
r) events occurring during the performance of stuntman activity,
s) uninsurable activities, i.e. events occurring during preparations for or the performance of extreme and "adrenaline" types of sports, or in direct association with them, e.g. activities such as contact martial arts, bungee jumping, mountaineering and potholing, alpine skiing, canyoning and parasailing,
t) events occurring during the performance of sports other than dangerous types within the framework of organised competitions and races, including training sessions; this exemption does not apply if the "***Sporting Competitions (S1)***" or "***Dangerous Sports (S2)***" types of Insurance are agreed,
u) events occurring in connection with preparations for and performance of dangerous types of sport, particularly aircraft sports, motor sports, motorboat sports, including water skiing, white-water sports, diving with breathing apparatus, mountain hiking in mountainous terrain more than 2,000 metres above sea level or on paths secured by chains, cables and ladders, horse-riding, skateboarding, bobsledding, skeletoning, ski acrobatics, ski-jumping and ice hockey; this exemption does not apply if the "***Dangerous Sports (S2)***" type of Insurance is agreed,
v) events occurring as a result of the performance of the Insured Person's working activity or employment; this exemption does not apply if the "***Working Stay***" Type of Insurance is agreed,
w) payments for healthcare aids not prescribed by an out-patient treatment doctor or any other doctor,
x) payments for medicines not prescribed by a doctor, i.e. on open sale without a medical prescription,
y) payments for medicines prescribed by an out-patient doctor; this exemption does not apply if the "***Out-patient Medicines***" type of Insurance has been agreed on.

2. The Insurance does not apply to:
a) the treatment of illnesses and states of health where healthcare is appropriate, expedient and necessary, but can be delayed and provided after the Insured Person returns to their State of Origin,
b) events occurring while the Insured Person remains on the territory of their State of Origin,
c) cases where travel is for the purposes of utilising healthcare.
d) events which the Insured Person intentionally brought about themselves or which the Beneficiary intentionally brought about for the Insured Person,
e) for events which another person brought about for the Insured Person at the behest of the Insured Person or the Beneficiary,

f) 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,
g) 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,
h) for events occurring during activities at locations not designated for such activities (e.g. skiing and other activities outside designated pistes, ski-jumping and the like),
i) if damage 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 disturbances and terrorist activities) in which the insured party has participated,
- the handling of a firearm or explosive by the Insured Person.
j) if a Loss Event has occurred as a result of or in connection with:
- disturbances or criminal activity which the Insured Person has brought about or committed,
- 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 30 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).

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 Insurer the Insurance Premium,
   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 it has received on their behalf from the Insurer,
   c) as soon as it 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 apply to the Policyholder.

Article 10
Obligations of the Insured Person

1. The Insured Person shall:

a) do everything to avert the occurrence of an 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 necessary, seek medical treatment and produce the Insurance 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 authorisation 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 organisations 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 the Loss Event and the extent of its consequences and to provide the Insurer with all the required cooperation upon request,

d) to inform the Insurer of all Insurance policies effective at the time of the Loss Event, providing Insurance coverage 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 the 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 code 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 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 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 provided. The amount of the Insurance Premium is determined by the Insurer.

2. Any change in Insurance risk within the duration of 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 return 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, the Policyholder or Insured Person incorrectly or incompletely answers 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 settlements 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 Settlement exceeding the amount of Insurance Premiums paid in.

7. Upon the 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 settlement 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 picked up 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 the 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 is provided 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 connected with taking out and administering the Insurance come to 20% of the prescribed 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 a court with jurisdiction in the Czech Republic in compliance with Czech law.