GENERAL CONDITIONS FOR VOLUNTARY HEALTH INSURANCE

OU-DZO-01/24

INTRODUCTORY PROVISIONS

Article 1

(1) These General Terms and Conditions of Voluntary Health Insurance (hereinafter: General Terms and Conditions) are an integral part of the Voluntary Health Insurance Contract (hereinafter: the Insurance Contract) that the Policyholder voluntarily concludes with Sava Neživotno osiguranje a.d.o. Belgrade, as an insurer.

(2) These General Terms and Conditions regulate the conditions and manner of organizing voluntary health insurance, the types of voluntary health insurance, the rights and obligations of the Insurer, the Policyholder and the Insured, the duration of voluntary health insurance, the conditions for concluding and terminating the Voluntary Health Insurance Contract and other conditions of importance for voluntary health insurance, in accordance with the law governing insurance and the law governing voluntary health insurance.

DEFINITIONS

Article 2

(1) Certain terms used in the General Terms and Conditions have the following meanings:

1. **Voluntary Health Insurance Insurer** (hereinafter: **the Insurer)** - "Sava Neživotno osiguranje" a.d.o. Belgrade, which organizes and implements voluntary health insurance in accordance with the law;
2. **Policyholder of voluntary health insurance** (hereinafter: **the Policyholder**) - is a legal or natural person, as well as other legal entities that in the name and on behalf of the Insured, i.e. in their own name and on behalf of the Insured, conclude the Voluntary Health Insurance Contract with the Insurer and who undertook to pay the insurance premium from their own funds or at the expense of the Insured's funds;
3. **Insured Voluntary Health Insurance** (hereinafter: **Insured Person)** - is a natural person who has concluded a Voluntary Health Insurance Contract or for whom a Voluntary Health Insurance Contract has been concluded with the Insurer and who exercises the rights set out in the Voluntary Health Insurance Contract, as well as a member of the Insured Person's family if he or she is covered by the Voluntary Health Insurance Contract;
4. **Family members -** are spouses or common-law partners, biological and/or adopted children of the Insured who are legally dependent persons until the age of 18, or until the age of 26 in case they are in full-time studies. Age restrictions do not apply to children who are incapable of living independently because of a degree of physical and/or mental impairment that prevents them from performing normal motor and/or bodily functions;
5. **Collective Insurance** - is voluntary health insurance concluded by the Policyholder for a group of Insured Persons for whom it has an interest in concluding an Insurance Contract;
6. **Voluntary Health Insurance Offer** (hereinafter: **Offer**) is a proposal for concluding a Voluntary Health Insurance Contract that the Insurer gives to a person who wishes to conclude an Insurance Contract;
7. **Cover sheet** - is a document that temporarily replaces the policy, and in which the essential elements of the insurance contract are entered;
8. **Voluntary Health Insurance Policy** (hereinafter: **Policy**) is proof of the concluded Voluntary Health Insurance Contract with the Insurer;
9. **Voluntary Health Insurance Document** (hereinafter**: document)** - is a document issued to the Insured by the Insurer based on which the Insured proves the status of the Insured Voluntary Health Insurance Insured and exercises the rights from the voluntary health insurance;
10. **Voluntary health insurance premium** (hereinafter: premium) is a sum of money paid by the Insured of Voluntary Health Insurance, i.e. the Policyholder to the Insurer, based on the concluded Voluntary Health Insurance Contract;
11. **First inclusion in insurance** - the first inclusion in insurance is considered to be an inclusion under a policy from which there is insurance continuously. If the insurance is not continuous, the first inclusion shall be considered to be the beginning of the insurance after the interruption;
12. **Continuous insurance** - re-conclusion of the policy for a person who was already insured under a voluntary health insurance policy with the same or another Insurer, with the same agreement without interruption or with termination in accordance with the decision of the Insurer;
13. **Insured amount** – is the amount of money that represents the maximum annual obligation of the Insurer under the concluded Voluntary Health Insurance Contract;
14. **Insured event** - means a future uncertain and independent event of the Policyholder, i.e. the Insured, and the occurrence of which gives rise to the obligation of the Insurer;
15. **Cash benefits** - benefits provided by the Insurer to the Insured in the case of contracted medical expenses, loss of earnings, i.e. salary or other incomes, due to the temporary inability to work, reimbursement of transport costs related to medical treatment and other types of financial benefits associated with the exercise of rights from voluntary health insurance defined by the Insurance Contract;
16. **Health services** - services provided by a health service provider in accordance with the law governing healthcare, and including measures for the prevention and early detection of diseases, examinations and treatment in the event of illness and injury or in connection with family

planning, medical rehabilitation, including methods and procedures of alternative and complementary, i.e. traditional medicine, which are safe; high-quality and efficient;

17. **Health Institution** - is a legal entity that performs healthcare activities and that has received a license from the Ministry in charge of health affairs (hereinafter: the Ministry) to perform healthcare activities in accordance with the law governing healthcare and regulations adopted for the implementation of that law;
18. **Health service provider** – collectively named healthcare institutions, private practice and other health service providers, which have received a permit from the Ministry responsible for health affairs, to perform certain tasks of healthcare in accordance with the law governing healthcare and regulations adopted for the implementation of that law.
    Providers of health services are also considered to be legal entities, entrepreneurs and counseling centers registered for the provision of speech therapy services or consultations with a psychologist and psychotherapist, as well as optician shops, if these services are covered by an insurance policy;
19. **Other providers of health services** - are other legal or natural persons who perform certain tasks in the field of healthcare, i.e. provide medical and technical aids, and who have received a license from the competent authority to perform these activities in accordance with the law;
20. **Private practice** - is another form of health service in which certain services of healthcare are performed and which has received the permission of the Ministry to perform certain tasks of healthcare in accordance with the law governing healthcare and regulations adopted for the implementation of that law;
21. **Network of healthcare institutions** - are healthcare institutions, private practice and other health service providers who, during the term of the Insurance Contract, have concluded with the Insurer a Contract for the Provision of Services that is in force, and in which the insured person uses the services agreed upon by the policy and in the manner provided for in the conditions;
22. **Previous health condition** - means any health condition resulting from a congenital, chronic or recurrent disease or injury occurring before the entry into force of the Insurance Contract, i.e. before the first inclusion in the insurance, and of which the Insured knew at the time of concluding the Insurance Contract.
    In particular, a pre-existing medical condition is considered to be a chronic illness, injury, illness or condition which can be expected to last for a long period of time without a reasonably foreseeable date of cessation and which may be characterized by remissions requiring ongoing or intermittent care and treatment, as appropriate;
23. **Accident -** any sudden and independent event which, acting mainly externally and abruptly on the body of the Insured, resulting in a deterioration of health that requires medical assistance;
24. **Waiting period** (hereinafter: grace period) - is an agreed period of time at the beginning of the insurance period, during which the Policyholder has the obligation to pay the insurance premium, and the Insurer is not obliged to pay insurance benefits regardless of the fact that the insured event occurred;
25. **Participation in the costs or** participation in part of the costs of the contracted medically justified treatment that the insured person must pay, if this is agreed upon by the policy, i.e. provided for in the terms of insurance;
26. **Special Conditions of Voluntary Health Insurance** (hereinafter: Special Conditions) - are the conditions of the Insurer that regulate the rights and obligations of the Contracting Parties for a specific type or combination of types of voluntary health insurance, which form an integral part of the Insurance Contract and which must be delivered to the Policyholder.

TYPES OF INSURANCE

Article 3

(1) The types of voluntary health insurance implemented by the Insurer are:
    1. Supplementary health insurance is insurance that covers the costs of healthcare that arise when the Insured supplements the rights from compulsory health insurance in terms of content, scope and standards, in accordance with the general and special conditions of the Insurer;
    2. Additional health insurance is insurance that covers participation in the costs of healthcare, i.e. covers the costs of health services, medicines, medical devices, or cash benefits that are not covered by the rights from compulsory health insurance, in accordance with the general and special conditions of the Insurer;
    3. Private health insurance is the insurance of persons who are not covered by compulsory health insurance or who have not been included in compulsory health insurance, to cover the costs of the type, content, scope and standard of rights contracted with the Insurer;
    4. Combination of the above types of insurance.

(2) Voluntary health insurance is also considered to be insurance in the event of the use of healthcare of the Insured during the stay abroad, if it is specifically contracted.

ACQUISITION OF THE STATUS OF THE INSURED

Article 4

(1) Voluntary health insurance can be used to insure all persons who express a clear intention, i.e. for whom the policyholder expresses a clear intention, to conclude a Voluntary Health Insurance Contract with the Insurer, regardless of age, health status, gender and exposure to the risk against which they are insured, in accordance with the law governing voluntary health insurance, these General Terms and Conditions and the special conditions of the Insurer for certain types of voluntary health insurance.

(2) The status of an insured person in voluntary health insurance can be acquired by any person who is a domestic or foreign citizen, who has a permanent residence, i.e. a permit for temporary residence or permanent residence in the Republic of Serbia;

(3) The status of an insured person in additional and supplementary health insurance may be acquired by a person who has the status of an insured person in the compulsory health insurance system in accordance with the law.

(4) For other types of insurance, the status of a person in the compulsory health insurance system is not taken into account when concluding the insurance contract.
(5) The status of the Insured may also be acquired by members of the Insured's family, in accordance with the Special Conditions, provided that voluntary health insurance has been contracted for them and if the agreed premium has been paid for them.

CONCLUSION OF AN INSURANCE CONTRACT

Article 5

(1) The Voluntary Health Insurance Contract is concluded based on a previous offer made by the Insurer to a person wishing to conclude a Voluntary Health Insurance Contract.
(2) If the Policyholder and the Insured of the Voluntary Health Insurance are not the same person, the written consent of the Insured is required for contracting the voluntary health insurance, if the payment of the premium is borne by the Insured of the Voluntary Health Insurance.
(3) The policyholder is obliged to provide proof of this consent at the request of the insurer.
(4) If the Insured is a minor, the Insurance Contract is signed by a parent or guardian.
(5) Special insurance conditions may be provided for cases in which the contractual relationship from the insurance arises from the payment of the premium itself.

OFFER

Article 6

(1) The offer contains important information about the contracting parties, i.e. the insured persons of voluntary health insurance, the date of commencement of insurance, the grace period, as well as the date of completion of insurance, the amount and deadlines for payment of the insurance premium, the maximum contracted amounts according to the risks of coverage and other important elements for contracting insurance.
(2) Essential information on the contracting parties, i.e. insured persons of voluntary health insurance referred to in paragraph (1) of this Article are:
   1) For a natural person:
      1. Name and surname, as well as date of birth of the Insured Voluntary Health Insurance Person,
      2. JMBG, i.e. registration number for foreign citizens,
      3. address of residence or residence in the Republic of Serbia (street and number, place and municipality),
      4. contact (phone number or e-mail address);
   2) for a legal entity:
      1. name, i.e. business name,
      2. Tax identification number and registration number,
      3. Address of the headquarters (street and number, place and municipality),
      4. Contact (phone number or e-mail address).
(3) In the case of collective insurance, the Policyholder may submit a single offer containing information on each individual person to be covered by collective insurance, which shall contain information on each individual person covered by collective insurance, as follows:
   1) name and surname, as well as date of birth of the Insured Voluntary Health Insurance Person;
   2) JMBG, i.e. registration number for foreign citizens;
   3) address of residence, i.e. residence in the Republic of Serbia (street and number, place and municipality);
   4) contact (phone number or e-mail address).
(4) The offer, as important data, also contains data on the previous health status of the Insured of Voluntary Health Insurance, if they are necessary for the Insurer to assess the risk of insurance.
(5) The policyholder, i.e. the insured person, is obliged to report to the Insurer, when concluding the Insurance Contract, all circumstances that are important for the assessment of risk, and which are known to him or could not have remained unknown to him.
(6) When contracting, the Insured is obliged, at the request of the Insurer, to fill out the Health Status Questionnaire (hereinafter: the Questionnaire), which is an integral part of the offer, or to perform a medical examination, as well as to submit medical reports and other necessary documentation with the aim of determining the risk, except in the case of collective bargaining when the Questionnaire is not mandatory.
(7) The cost of the medical examination within the meaning of the previous paragraph of this Article shall be borne by the Insured.
(8) The data from the Questionnaire cannot be a reason for refusing admission to voluntary health insurance.
(9) If, in the period from the submission of the offer to the conclusion of the Insurance Contract, there is an increase in the risk to the health of the insured person with individual health insurance, the insured person is obliged to inform the Insurer immediately upon becoming aware of this fact. Increased threats to the health of the insured person are considered to be all diseases, i.e. diseases, changes of occupation, injuries of the insured person, playing sports or traveling to crisis areas, tropical regions or expeditions, as well as other changes that increase the risk to the health of the insured person.
(10) The offer for the conclusion of the Insurance Contract is binding on the Insurer if it has not set a shorter period, for the period of 8 (eight) days when the Insurer received the offer, and if a medical examination is required for a period of 30 (thirty) days.
(11) Depending on the degree of risk to which the Insured is exposed, the Insurer has the right to offer changed insurance conditions, i.e. to increase the premium or change the amount or scope of coverage.
(12) In the event that the Bidder does not agree to the amended conditions in the case defined in the previous paragraph of this Article, within 8 days of receipt of the registered letter, with the proposal for insurance with the changed conditions of the Insurer, upon the expiration of this period, the Contract shall be considered terminated, i.e. it shall be considered that the Bidder has withdrawn from the insurance offer.

POLICY, COVER SHEET AND DOCUMENT

Article 7

(1) The insurer issues the policy as proof of the concluded Insurance Contract and makes it in two copies, one of which is retained by the Contractor or the Insured, and the other is retained by the Insurer. In the event that the Contract is concluded by paying the insurance premium, the Insurer submits a confirmation.
(2) Notwithstanding the preceding paragraph of this Article, the Insurer may issue a cover sheet.

(3) In the case of the Collective Insurance Contract, the Insurer issues one insurance policy that covers all persons who are on the list of the Policyholder, i.e. an excerpt from the personnel records that forms an integral part of the Insurance Contract, i.e. the insurance policy.
(4) In the event that the Insurance Contract is concluded for the Insured's family members, the Insurer may issue one insurance policy covering the members of the Insured's family, where the Policyholder is the person insured by the collective policy.
(5) The policy, i.e. the cover sheet, contains:
1) the name and surname of the Insured Voluntary Health Insurance or the Contractor, i.e. the name of the Contractor;
2) the date of birth of the Insured Voluntary Health Insurance Person;
3) domicile, i.e. residence and address of residence of the Insured Voluntary Health Insurance or the Contractor, i.e. the registered office of the Contractor;
4) personal identification number, i.e. registration number for foreign nationals, i.e. tax identification number and registration number of the Contractor;
5) the name and address of the Insurer;
6) insurance coverage;
7) the sum and risk of insurance;
8) the amount of the premium, the manner and conditions of payment of the premium;
9) reference to the tariff at which the premium was calculated;
10) the number of the policy, i.e. the list of coverage;
11) the number of the offer for concluding the Voluntary Health Insurance Contract;
12) the date of commencement of insurance, the grace period and the period of validity of the insurance, i.e. the policy or cover sheet;
13) Signature of an authorized person with the Insurer;
14) signature of the Voluntary Health Insurance Contractor;
15) the place and date of issuance of the policy, i.e. the list of coverage;
16) 16) Other data in accordance with the law.
(6) An integral part of the Voluntary Health Insurance Contract are the general and special terms and conditions of voluntary health insurance.
(7) Based on the insurance policy, the Insurer is obliged to issue to each Insured, on the day of issuance of the policy, and no later than within 60 days, a document containing the following information:
1) the business name of the Insurer;
2) name and surname, as well as date of birth of the Insured Voluntary Health Insurance Person;
3) Personal identification number of the Insured Voluntary Health Insurance, i.e. registration number for foreign citizens;
4) the amount of coverage;
5) the number of the policy;
6) The period of validity of the document.
(8) By means of the Document, the Insured proves the status of the Insured and exercises the rights from voluntary health insurance, exceptionally based on a policy or a cover sheet in the following cases:
- Until the time of obtaining the document
- If you are entitled to health insurance directly from the insurer.
- If the insurance contract is concluded for a period of 90 days or less.

(9) The Document is valid with a personal identification document.
(10) The insured is obliged to report to the Insurer in writing without delay the loss, theft or damage of the document, in which case the Insurer issues a duplicate document.

DURATION OF THE INSURANCE CONTRACT

Article 8

(1) An insurance contract cannot be concluded for a period of less than 12 months.
(2) Notwithstanding paragraph 1 of this Article, voluntary health insurance may last even shorter, as follows:
1. during the insured person's stay abroad, i.e. to cover the costs of healthcare provided abroad;
2. in the event that the status of an insured person in the compulsory health insurance system lasts for a shorter period in accordance with the law;
3. during the temporary stay in the Republic of Serbia of the Insured Person, who is a foreign citizen or a stateless person;
4. for persons who, during the agreed insurance period, have acquired the basis for insurance in collective agreements;
5. If the issuance of the policy is preceded by the closure of the cover list.

(3) Insurance coverage begins at the expiry of the 24.00 hours, the day stated in the policy as the beginning of the insurance, if the Policyholder has paid the premium by then, but not before the expiry of the 24.00 hours, the day on which the premium was paid, i.e. the first installment of the premium.
(4) Insurance coverage ends at the end of 24:00 on the day specified in the policy as the expiration date of the insurance.
(5) If a waiting period has been agreed, the Insurer's obligation begins at the twenty-fourth hour of the day specified as the date of expiry of the waiting period, provided that the insurance premium has been paid.
(6) Insurance coverage terminates even before the agreed deadline in the following cases:
1. death of the Insured - on the day of death;
2. exclusion from insurance of the insured person by the Policyholder in the case of collective insurance;
3. termination of the Agreement in accordance with Article 14 of these General Terms and Conditions.

(7) In any case, with the termination of insurance coverage for the Insured, the insurance of family members also ceases, regardless of the reason for the termination of the status of the insured person.

EMERGENCY

Article 9

(1) An insurance contract may stipulate a grace period, i.e. a period of time in which the Insurer is not obliged to pay insurance benefits if an insured event occurs.
(2) The grace period is calculated from the beginning of the insurance defined in the policy, provided that the first contracted premium is due by that date.
(3) If the due premium has not been paid by the beginning of the insurance, the grace period is calculated at the end of the 24:00 hour of the day on which the first contracted premium was paid.
(4) The grace period does not apply to the renewal of the Contract, unless otherwise defined in the Insurance Contract.

The provisions of this paragraph shall apply only to the Insured Persons who, by the previous policy, i.e. the Insurance Contract, have acquired the status of the Insured, i.e. for whom the grace period has already expired during the term of the previous policy. If the grace period has not fully expired during the term of the previous policy, the remaining period until the total waiting period is carried over to the next insurance period under the new policy.

(5) The insurer may provide for a grace period for certain insurance coverage, in accordance with the Special Terms and Conditions.

PREMIUMS AND CONSEQUENCES OF NON-PAYMENT OF PREMIUMS

Article 10

(1) The insurance contract, i.e. the insurance policy, agrees on the amount and method of payment of the premium.
(2) The amount of the premium is determined by the Insurer in accordance with the premium tariff and regulations governing the field of voluntary health insurance.
(3) The insurer may not increase the amount of the insurance premium during the period for which the Voluntary Health Insurance Contract is concluded.
(4) Notwithstanding paragraph (3) of this Article, the insurance premium may be changed:
    1. in the case of Contracts concluded for several years after the expiry of a period of 12 months from the date of conclusion of the Contract, i.e. every 12 months until the expiry of the period for which the Contract was concluded;
    2. in the event that the Policyholder, when concluding the Insurance Contract, has omitted important circumstances relevant to the risk assessment.
(5) The policyholder is obliged to pay the premium to the Insurer in an orderly manner, on maturity, within the deadlines determined by the Insurance Contract or policy.
(6) If it is agreed that the annual premium is to be paid in semi-annual, quarterly or monthly installments, the Insurer has a right to the premium for the entire year of the insurance period. Exceptionally, in the event of termination of insurance due to the death of the Insured, the Insurer is entitled to the premium until the day of the Insured's death.
(7) The Insurer shall be entitled to charge the Policyholder a statutory default interest for each day exceeding the deadline within which it is obliged to pay the due insurance premium.
(8) The first contracted insurance premium, i.e. the first installment of the premium, is due by the date of commencement of the Insurance Contract.
(9) Each subsequent instalment of the insurance premium is due on the last day of the current period of payment of the insurance premium, for the following period of time.
(10) The payment of the arrears of the premium is always related to the first unpaid installment of the premium.
(11) The premium is considered to have been paid when it is credited to the Insurer's account.
(12) The insurer is obliged to accept the premium paid from any person who has a legal interest in the premium being paid.
(13) If the Policyholder fails to pay the due contracted premium, i.e. the installment of the premium, the Insurer's obligation to cover the costs, i.e. part of the costs for the provision of health services covered by the Insurance Contract or policy, shall cease upon the expiration of the period of 30 days from the date on which the Policyholder was delivered a written notice of due and unpaid premiums.
(14) After the expiry of the period referred to in paragraph (10) of this Article, the Insurer may terminate the Insurance Contract without subsequent notice and initiate the procedure for the collection of due premiums with the corresponding interest before the competent court.

RIGHTS AND OBLIGATIONS OF THE INSURER

Article 11

(1) The insurer provides the same scope, content and standard for the exercise of rights and obligations within a particular type of voluntary health insurance that it organizes and implements for all Insured Voluntary Health Insurance Policy.
(2) The Insurer is obliged to provide the Insured with the exercise of the rights from voluntary health insurance determined by the Insurance Contract, as well as the rights determined by these General Terms and Conditions, special conditions and the Insurance Contract.
(3) The insurer is obliged, in accordance with the Insurance Contract, i.e. the policy, these General Terms and Conditions and Special Conditions, to reimburse the insured/health service provider for the costs of treatment or part of the costs of treatment incurred by exercising the rights from voluntary health insurance, within 14 days, from the day on which it received complete documentation based on which it can be determined the indisputable existence and scope of the obligation.
(4) The insurer shall notify the Contractor of changes to the general or special terms and conditions of voluntary health insurance within the period referred to in paragraph 3 of this Article, with an explanation, unless they are more favourable to the Contractor.
(5) The Insurer is obliged to provide the Contractor, i.e. the Insured, with all information in a timely manner, as well as the necessary documentation, i.e. excerpts from the documentation kept by the Insurer, which relate to the implementation of voluntary health insurance, and which are important for the exercise of rights from the Contract, as well as information from which health service providers can exercise the rights from voluntary health insurance, information that is a trade secret. This information is provided to the Insured without paying a fee.
(6) The sum insured specified in the policy is the upper limit of the Insurer's obligation under the Insurance Contract.
(7) The Insurer shall have the right to request from the Insured, the Contractor or any other legal or natural person subsequent explanations or additional documentation, in order to determine important circumstances related to the reported insured event.
(8) The insurer has the right to send the insured person for a control examination or an additional medical examination, which would determine the necessary facts regarding the reported insured event, and the costs of such an examination shall be borne by the Insurer.
(9) At the time of renewal of insurance, the Insurer has the right, based on the history of claims or additional information received from the Insured, to propose the renewal of the Insurance Contract with a change in the premium or limitation of the Insurer's liability, regardless of the insurance continuously.

(10) In the event of an increase in the amount of the insurance premium, in accordance with the law and these conditions, the insurer is obliged to inform the Contractor in writing about the increase in the amount of the premium at least 30 days before the end of the current insurance year, with an explanation.

EXCLUSION OF THE INSURER'S LIABILITY

Article 12

(1) The Insurer's obligation is excluded in the following cases:
   1) If the Insured has provided incorrect and untrue information, i.e. concealed important circumstances that have an impact on the conclusion of the Insurance Contract;
   2) If the Policyholder, i.e. the Insured does not pay the due premium by the agreed deadline, nor does it do so for him by another person who has a legal interest in the premium being paid;
   3) In case of misuse of the policy or document;
   4) If the scope of contracted health services and the amount of costs is exceeded;
   5) If the claim is based on false information and false documentation;
   6) In other cases, under the special conditions of the insurer

(2) The insurer is not obliged to reimburse the costs incurred as a result of:
   1. intentional acts or gross negligence of the Insured;
   2. natural disasters or natural disasters (earthquakes, floods, storms, landslides, etc.);
   3. epidemics and pandemics of major significance involving the occurrence of severe forms of communicable diseases, including death, unless otherwise agreed;
   4. if the insured event occurred as a result of a technical-technological accident that may endanger the life and health of a large number of people on a larger scale (accidents at electric power oil and gas plants, accidents in the handling of radioactive and nuclear materials, severe pollution of soil, water and air, etc.);
   5. war events or armed actions, except for the Insured's participation in them by his profession or at the invitation of authorized state authorities;
   6. events directly attributable to invasion, armed conflict, civil war, insurrection, terrorism, rebellion or revolution, vandalism, physical confrontation (other than proven self-defense) or a criminal offense;
   7. attempted or committing suicide, willful self-harm or mental illness (insanity) of the Insured for any reason;
   8. the fact that the Policyholder, the Insured or the beneficiary intentionally caused the insured event;
   9. the fact that the Insured has voluntarily exposed himself to dangers that endanger his life (except in the case of saving someone's life, but not for participating in searches);
   10. for injuries and diseases that have arisen as a result of alcohol consumption (presence of alcohol in the blood over 0.3%0, i.e. 6.48 mmol/l) or addiction (alcohol, drugs, drugs, etc.);
   11. preparing, attempting or committing a criminal offence with intent, as well as fleeing after such an act;
   12. engaging in risky sports and activities (professional, amateur or recreational) such as: hunting, karting, acrobatics (rollerblading, skiing and others), parkour, street boarding, mountaineering, handling of pyrotechnics, ammunition and explosives, ski jumping, bobsledding, acrobatic skiing, automobile, aviation, motorcycle and nautical racing, as well as other speed competitions, parachuting, hang gliding, paragliding, bande-jumping, rafting, inline skiing and similar physical activities that carry an increased risk of endangering life and health, especially those that are carried out with mandatory protective or special equipment.

RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED

Article 13

(1) The rights under the Insurance Contract are exercised by the Insured based on the insurance document (or policy), which he is obliged to show to the health service provider for inspection in the case of insurance reimbursement of medical expenses.

(2) The right to reimbursement of medical expenses or other financial compensation is exercised by the Insured under the terms of the Insurance Contract valid on the day of the occurrence of the insured event.

(3) The insured is obliged to:
   1. before using the service in the institution in the Network, the authorized person of the service provider provides an identification document and document;
   2. to inform the Insurer as soon as possible about the loss of the document;
   3. not to give the document to other persons for use and to provide truthful information in the process of exercising insurance rights always and everywhere and to act in accordance with the law;
   4. to return the document to the Insurer in case of loss of the status of the Insured before the expiry of the Insurance Contract in collective insurance.

(4) The Insured (and in the case of the Insured is a minor, a parent) is obliged to be familiar with the coverage that has been contracted for him and not to receive the service at the expense of the insurance if it is not covered by the policy.

(5) The insurance policyholder is obliged to pay the insurance premium duly upon maturity.

(6) If the Policyholder and the Insured are not the same person, the Policyholder is obliged to fully inform the Insured about the terms and conditions of the insurance, i.e. to inform the Insured about the rights to compensation arising from the contracted voluntary health insurance.

(7) The policyholder, i.e. the Insured, is obliged to submit to the Insurer all the documentation necessary to determine the existence of the basis, scope and amount of the Insurer's liability.

(8) The insured is obliged, at the request and at the expense of the Insurer, to perform a medical examination in order to establish the necessary facts regarding the reported insured event;

(9) The insured is obliged to authorize doctors and healthcare providers to provide, at the request of the Insurer, all necessary information regarding his treatment as well as all non-essential information regarding his previous health condition.

(10) The policyholder, i.e. the Insured, is obliged to inform the Insurer as soon as possible about all changes in the data on the insured persons, such as change of address of residence, change of surname, occupation, marital status, termination of employment, etc.

(11) The rights under the insurance contract cannot be inherited or transferred to other persons.

Cash benefits that are due and remain unpaid due to the death of the Insured may be inherited in accordance with the law.

TERMINATION AND CANCELLATION OF INSURANCE CONTRACTS

Article 14

(1) The Insurer may not terminate the Insurance Contract before the expiry of the period for which the Contract was concluded, except in the following cases:
   1. if the Contractor, i.e. the Insured, has made an incorrect application, or has omitted a circumstance that is of such a nature that the Insurer would not have concluded the Contract under the same conditions if it had known about the true state of affairs;
   2. non-payment of the contracted insurance premium;
   3. termination of the status of an insured person in the compulsory health insurance system for the Insured Voluntary Health Insurance during the term of the Contract on Supplementary or Additional Voluntary Health Insurance;
   4. in other cases provided for by special conditions and the law.

(2) In the event of termination of the Contract referred to in paragraph (1) (1) of this Article, the Insurer shall be entitled to the full amount of the due premium.

(3) The policyholder may not unilaterally terminate the policy, except in cases defined by law.

(4) Any contracting party may terminate the Insurance Contract with an indefinite term of validity, if the Contract has not been terminated on some other ground.

(5) Cancellation must be made in writing, no later than three months before the end of the insurance year.

(6) If the insurance is concluded for a period longer than five years, each party may, after the expiry of the agreed period, with a notice period of six months, declare in writing to the other party that it terminates the Contract.

OBJECTION OF THE INSURED

Article 15

(1) An insured person who believes that his rights under the Insurance Contract have been violated by the decision of the Insurer on the claim may file a complaint with the Insurer within 30 (thirty) days from the date of receipt of the Insurer's decision.

(2) The Insurer is obliged to make a decision on the complaint within 15 days from the date of receipt of the Insured's complaint and inform the Insured of the decision.

INFORMATION ON INSURED PERSONS

Article 16

(1) The Policyholder and the Insured with their signature on the policy authorize the Insurer to collect, verify, process, store, transfer and use personal data necessary for the conclusion and implementation of the Insurance Contract in accordance with the law governing the field of personal data protection.

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

(3) When concluding the Insurance Contract, the Insurer will not ask for genetic data, i.e. the results of genetic tests for the Insured, as well as for their relatives, regardless of the line and degree of kinship.

STOP IN THE RULES

Article 17

(1) The rights of the insured person towards the third party are transferred to the Insurer, in the amount of the obligation paid by the Insurer, without obtaining the special consent of the Insured.

(2) In order to exercise the right of recourse, within the meaning of paragraph (1) of this Article, the Insured is obliged to provide the Insurer with all evidence requested by the Insurer in connection with the claim for damages. The costs of obtaining this evidence are borne by the Insurer.

(3) If the Policyholder or the Insured receives compensation from a third party liable for the damage, the Insurer has the right to deduct that amount from the compensation to be paid to the insured person, based on the policy.

TRANSITIONAL AND FINAL PROVISIONS

Article 18

(1) Claims from the Insurance Contract are time-barred under the provisions of the Law on Obligations.

(2) All relations of the contracting parties, which are not regulated by these General Terms and Conditions, are subject to the Law on Obligations and other legal regulations of the Republic of Serbia.

(3) The General Terms and Conditions or Special Terms and Conditions may be amended according to the procedure and in the manner in which they were adopted.

(4) The Insurer is obliged to publish the updated General and Special Terms and Conditions on its official website, as well as to make them available in writing at all points of sale of the Insurer or in another appropriate manner.

(5) For Insurance Contracts that are in progress, until the end of the insurance year, the General or Special Terms and Conditions based on which these Contracts were concluded apply, unless the change in terms and conditions occurred due to a change in legal regulations, which the Insurer cannot influence.

(6) The Contracting Parties shall resolve all disputed issues amicably, and if they fail to do so, they shall agree on the jurisdiction of the court according to the seat of the Insurer.

Article 19

(1) These General Terms and Conditions enter into force on the day of publication and apply from 16.05.2024. Publication is made by displaying it on the notice board of the Company on the day of its adoption.

(2) For all insurance contracts entered into prior to the entry into force of these Terms and Conditions, the Terms and Conditions in force at the time of the conclusion of such contract shall apply.