INSURANCE TERMS AND CONDITIONS OF **DAILY ALLOWANCE INSURANCE DURING HOSPITALISATION AS A CONSEQUENCE OF AN ACCIDENT**

HOSP CIZ 1/21

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POJIŠŤOVNA VZP, a. s.

Chráníme to nejcennější

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Art. 1

Introductory provisions

1. The rights and responsibilities of parties to this **Insurance of Daily Allowance During Hospitalization** (hereinafter in this section also merely as "Insurance") is governed by the laws of the Czech Republic, particularly by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up an integral part thereof.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer

Art. 2

Definition of Terms

The following definitions of terms shall apply for the purposes of this insurance:

1. **Without undue delay** is a very short period, up to a maximum ranging in days, which means urgent, immediate, imminent, or direct action leading to the fulfil of an obligation or to the execution of a legal act or other manifestation of will, given that the period of its duration will depend on the circumstances of the individual case.
2. **The Duration of the Insurance** is the actual period of time within the agreed Term of Insurance for which the Insurance was in effect.
3. **Hospitalisation** is understood to mean the state of the Insured Person caused by an Insured Peril, when he/she is provided with the necessary hospital diagnosis and curative care connected with his/her stay in bed.
4. **One Hospitalisation Day** is every full 24 hours of continuous stay in hospital.
5. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one and the same cause, at the same place and the same time, comprising all the facts and their consequences, amongst which there is a causal, territorial, chronological or other direct connection.
6. A **Single Premium** is a premium determined for the entire period for which the Insurance has been agreed.
7. **Period** given in days is always understood to be the number of calendar days**.**
8. A **Random Event** is an event that is possible and in respect of which it is uncertain whether it will even occur within the Duration of the Insurance, or the time of its occurrence is unknown.
9. **Agreed Sum Insurance** is Insurance the purpose of which is to obtain a sum, i.e. an agreed financial amount, as a consequence of an Insured Event in an amount that is independent of the occurrence or extent of the loss.
10. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
11. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the Policyholder.
12. The **Term of Insurance** is the period for which the Insurance was agreed.
13. An **Insured Event** is an accidental state of affairs brought about by the Insured Peril, associated with the establishment of an obligation on the part of the Insurer to provide an Insurance Benefit.
14. An **Insured Peri**l is the possible cause of an Insured Event (the "cause").
15. The **Insurance Period** is the period of time agreed in the insurance policy for which the premium was paid. The first day of the first Insurance Period is the day of the commencement of the Term of Insurance. In the case of this Insurance, the Insurance Period is equal to the Term of Insurance.
16. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
17. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
18. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
19. The **Insured Person** is a person in respect to whose life or health the insurance relates.
20. A **professional athlete** is a person who has concluded a professional contract with a sports club or other entity in this field and/or engages in sporting activity for remuneration, which is this person's main or predominant income, and/or engages in sporting activity for a duration of at least 20 hours per week (including weekend), including training.
21. A **professional sporting activity** is a sporting activity carried out by a person who is a professional athlete as defined in this Article.
22. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
23. A **Party to the Insurance** is the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or obligation arose under the private insurance.
24. An **Accident** is understood, for the purpose of this Insurance, to be the unexpected and sudden action of external forces or one's own strength independent of the insured person's will, which occurs during the Duration of the Insurance and results in damage to the insured person's health or his/her death, including work Accidents. An Accident is deemed to occur the moment that the external forces or influences damaging the health or causing the death of the insured person came to bear.
    Damage to the health of an Insured Person caused by:
    a) localised festering following invasion of pathogens into an open wound caused by an Accident,
    b) tetanus or rabies infection in the course of an Accident, diagnostic, therapeutic and preventive interventions carried out to treat the consequences of an Accident,
    c) unexpected and uninterrupted exposure to high or low outdoor temperatures, gases, vapours, electric current (including lightning), radiation, toxic substances and poisons ((with the exception of microbial poisons and immunotoxic substances),
    d) drowning and death by drowning,
    e) bite, sting, or stabbing by an insect
    is also considered to be an Accident.
25. An **Interested Party** is a party interested in concluding an insurance policy with the Insurer.

Art. 3

Purpose and Subject of the Insurance

1. In the event of the occurrence of an Insured Event the Insurer shall provide the Beneficiary with a lump-sum insurance benefit in the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person.
4. The Insurance is concluded as Agreed Sum Insurance.

Art. 4

Insured Event

1. With the exception of the agreed exclusions, an Insured Event is the hospitalisation of the Insured Person in a healthcare facility at the place of Insurance commenced within the Duration of the Insurance due to Insured Perils occurring within the Duration of the Insurance after the expiry of the agreed Qualifying Period and during the Insured Person's stay at the place of Insurance
2. Insured Perils is Injury.

Art. 5

Extent and Place of Insurance

1. The extent of the agreed Insurance is determined by the Insurance terms and conditions and electable parameters stipulated in the insurance policy. These parameters are elected by the Policyholder upon concluding the insurance policy based on knowledge of the needs of the Insured Persons.
2. The Insurance is only effective in the agreed place of Insurance, which is the **territory of the states of the Schengen area, including the Czech Republic**.
3. The Policyholder shall elect the period insured and the upper limit of the Insurance Benefit (insured amount), which is stipulated in the other sections of these Insurance terms and conditions.
4. **Insurance of activities and sports**
    The Insurance covers the conducting of recreational and leisure activities and sports stipulated in the List of Activities and Sports (hereinafter referred to as the "List") as **activities and sports without the need for supplementary insurance**, which forms an annex to these Insurance terms and conditions. This Insurance does not cover the other activities and sports stipulated in the List **as activities and sports with the need for supplementary insurance (hazardous, extreme) or uninsurable**.

Art. 6

Extent and Due Payment of the Insurance Benefit

1. The insurer shall provide an insurance benefit to the extent contractually agreed as at the date of the insured event occurring.
2. The amount and extent of the Insurance Benefit is determined by the Insurer in accordance with the Insurance terms and conditions.
3. The payment of an Insurance Benefit is conditional on the occurrence of an Insured Event and the meeting of all the conditions and obligations ensuing from the insurance policy and parts thereof, namely the payment of the premium.
4. The Insurer renders an Insurance Benefit to the Beneficiary in the manner specified in subsequent sections for individual types of Insurance.
5. Unless otherwise agreed by the contracting parties, the Insurance Benefit shall be payable in the currency of the Czech Republic and its territory and the Insurer shall pay it to the Beneficiary by transfer to this person's bank account or by postal order to his name and address.
6. If the Insured Person was entitled to receive the Insurance Benefit, that he/she did not receive whilst alive, and his/her death was not an Insured Event this unpaid Insurance Benefit shall become the subject of inheritance proceedings.
7. The Insurance Benefit has an upper limit. The upper limit for the Insurance Benefit is the insured amount stipulated for individual types of Insurance in the insurance policy.
8. An Insurance Benefit is payable within 15 days from the end of investigations of the notified event, with which the claim for the Insurance Benefit is connected. The investigations conclude upon there porting of its results to the person who exercised the claim to the Insurance Benefit.

9. If it is not possible to conclude the investigations necessary to ascertain the Insured Event, the extent of the Insurance Benefit or to ascertain the person entitled to receive the Insurance Benefit within three months of the notification date, the Insurer shall inform the notifier why the investigations cannot be concluded; if requested by the notifier, the Insurer shall inform the notifier of the reasons in writing. The Insurer shall provide the person who exercised the claim to the Insurance Benefit with an appropriate advance on the Insurance Benefit on the basis of this person's request; this shall not apply if there are reasonable grounds to deny the provision of such an advance.
10. The Insurer is entitled to reduce the Insurance Benefit:
    a) if a lower premium was agreed as a consequence of a breach of a duty of the Policyholder or the Insured Person when negotiating the conclusion of the policy or its amendment, the Insurer shall be entitled to reduce the Insurance Benefit by an amount equal to the ratio of the premium it received to the premium it ought to have received,
    b) if the breach of the duty of the Policyholder, Insured Person or another party entitled to the Insurance Benefit had a material effect on the occurrence of the Insured Event, its course, on increasing the extent of its consequences or on ascertaining or determining the amount of the Insurance Benefit, the Insurer shall be entitled to reduce the Insurance Benefit proportionally to the effect that this breach had on the extent of the Insurer's duty to render benefits,
    c) in the event of the thwarting of the passing of the right to the Insurer pursuant to Article 18,
    d) if it paid the Insurance Benefit in the unreduced amount and has subsequently acquired a claim to reduce the Insurance Benefit. The Insurer is entitled to exercise a claim to the difference between the paid-out and the reduced Insured Benefit from the person in whose favour it was paid.
11. The Insurer is entitled refuse to pay the Insurance Benefit if the Insured Event was caused by a fact
    a) of which it learned only after the occurrence of the Insured Event,
    b) which it was unable to ascertain during the conclusion of the policy or its amendment as a consequence of the culpable breach of the obligation stipulated in paragraph 1 or 2 of Article 17 of this section,
    c) the awareness of which at the time of the conclusion of the insurance policy would result in it not concluding it or concluding it under different terms and conditions.
12. If the Policyholder or the Insured Person breaches any of the obligations set forth in these Insurance terms and conditions, the Insurer may reduce the Insurance Benefit with respect to the seriousness and nature of the breach of this obligation.
13. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with a lump-sum Insurance Benefit in an amount corresponding to the product of the insured amount stipulated in the insurance policy for this Insurance and the number of days of hospitalisation. The number of days of hospitalisation is limited to the maximum hospitalisation period.
14. The insurance benefit is determined by the insured amount. Its concrete amount is elected by the Policy and stated in the insurance policy.
15. The maximum hospitalisation period is, in the case of injury, 365 days for the Duration of the Insurance (Term of Insurance).
16. The hospitalisation period is always counted from the first day of hospitalisation.
17. The first and last day of hospitalisation is counted as one day.
18. The Insurer does not provide an Insurance Benefit for hospitalisation lasting less than 24 hours.
19. Investigations of an event may be concluded not earlier than the end of hospitalisation or the expiry of the maximum hospitalisation period. Should rthe hospitalisation last longer than three months, the Insurer may, upon a written request and following the submission of all the required documents, provide the Beneficiary an appropriate advance.

Art. 7

Exclusions from the Insurance

An Insured Event does not include:

1. events where medical treatment is provided as a result of accident for which the Insured Person was treated prior to the Insurance being taken out,
   or events where medical treatment is provided in connection with the treatment of accident, the cause or symptoms of which occurred prior to the Insurance being taken out,
2. events associated with:
   a) performances and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional,
   b) cosmetic measures,
   c) spa and convalescent treatment and stays, treatment at specialist treatment facilities (including long-term care facilities, sanatoria and hospices) and at facilities for subsequent ward treatment care,homeopathy and acupuncture,
3. psychiatric disorders, psychological tests and psychotherapy,
4. homeopathy and acupuncture,
5. complications that arise in connection with the provision of healthcare for injuries to which the Insurance does not apply,
6. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
7. events which the Insured Person brought about intentionally (including suicide or attempted suicide) or which were caused by the intentional conduct of the Policyholder or the Beneficiary,
8. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
9. events arising in connection with a riot which the Insured Person provoked, or in connection with criminal activity which the Insured Person committed or attempted to commit,
10. events which have occurred as a result of or in connection with the usage of, or the consequences of the usage of, alcohol, drugs, narcotics or other psychotropic or addictive substances by the Insured Person, even in the case of the voluntarily as well as proven treatment of additions to alcohol, addictive substances or gambling addiction, including stay in a detoxication facility or in a treatment facility for the other said addictions,
11. events which have occurred during test trials of Transport Means and during stunt activities,
12. events occurring during the preparation for and conducting of activities and sports not covered by this Insurance under the scope set out in Article 5(5) of this Section,
13. events occurring during the conducting of a sport performed by a Professional Athlete,
14. events associated with driving a motor vehicle, when the Insured Person refuses to undergo a test to determine the content of alcohol, toxic or narcotic substances in his blood,
15. events which the Insurer Person failed to document by providing proof of their duration, or failed to provide documentation that the Insurer requested or demanded of him in the course of the investigation of the Insured Event,
16. events which have occurred as a consequence of or in connection with:
    - the effects of released nuclear energy, or of chemical or biological weapons,
    - wartime events or civil war,
    - acts of violence (including civil disturbances and terrorist activities), in which the Insured Person took an active part,
    - handling of a firearm or explosive by the Insured Person.
17. hospitalisation related solely to the need for care providing by a nurse or a guardian,
18. events whereby the Insured Person failed to comply with the legislation in force in the country of his/her stay,
19. that part of hospitalisation surpassing the maximum hospitalisation period.

Art. 8

Insurable Interest

1. Insurable interest is a legitimate need for protection from the consequences of the Insured Event.
2. The Policyholder has an insurable interest in his own life and health. It is understood that the Policyholder also has an insurable interest in the life and health of another person, if he/she demonstrates an interest conditional on his relationship to this person, whether resulting from a family relationship or being conditional on the benefit or advantage he/she gains from a continuation of this person's life or preservation of this person's health.
3. If the Insured Person consented to the Insurance it is understood that the Policyholder's insurable interest was demonstrated.
4. The insurance policy shall be invalid if the Interested Party did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.
5. The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.
6. The insurable interest does not terminate upon the taking up of similar private insurance or for reason of plain disinterest.
7. The termination of the insurable interest must always be proven to the Insurer.

Art. 9

Group Insurance

1. Group Insurance is insurance pertaining to a group of Insured Persons, as further defined in the insurance policy, whose identity need not be known at the time of the insurance policy being concluded.
2. If the Insurance applies to members of a certain group, the insurance policy need not specify the names of the Insured Persons, on the condition that the Insured Persons can be identified beyond doubt at least at the time of the Insured Event.
3. In the case of group insurance, a breach of the duty to give truthful and complete answers to the Insurer's questions only impacts the Insurance of those persons to whom a breach of this duty applies.

Art. 10

Conclusion of the Insurance Policy

1. The insurance policy is concluded for a definite time period and in writing, otherwise it shall be deemed invalid.
2. The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated therein.
3. If the Policyholder accepted the offer for the conclusion of an insurance policy by the timely payment of the premium in its full amount or of the full amount of the agreed premium instalment, it shall be deemed that the written form of the insurance policy has been duly observed.
4. An integral part of the insurance policy, apart from the Insurance terms and conditions, are also all agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, duration, alteration and expiration of the Insurance (e.g. testimonies, agent´s records of the course of concluding the insurance, information for the client).

Art. 11

Commencement and Duration of the Insurance – Term of Insurance

1. The Insurance is concluded for a fixed Term of Insurance from the commencement of the Term of Insurance to the end of the Term of Insurance.
2. The Term of Insurance and the Insurance period are agreed in the insurance policy.
3. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Term of Insurance, but no earlier than on the day following the day on which Insurance premium is paid, unless agreed otherwise in the insurance policy.
4. The Insurance lasts from its commencement until the actual expiration of the Insurance.
5. The Insurance cannot be suspended for reason of the non-payment of the premium.

Art. 12

Amendments to and Termination of the Insurance Policy. Expiry of the Insurance

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.
2. The personal Insurance expires upon the lapsing of the Term of Insurance, i.e. at 24:00 hours on the day agreed as the date of the termination of the Term of Insurance.
3. The personal Insurance expires upon the termination of the insurable interest, on the date when the Insured Person dies or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.
4. The Insurer or the Policyholder may terminate the insurance in writing:
   a) within two months of the conclusion of the insurance policy. An eight-day notice period shall commence running upon the serving of the termination notice, with the insurance expiring upon the passing of this period
   b) within three months of the serving of the notification of the occurrence of the insured event. A one-month notice period shall commence running upon the serving of the termination, with the insurance expiring upon the passing of this period.
5. The Policyholder may terminate the Insurance subject to an eight day notice period:
   a. within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit,
   b. within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer,
   c. within one month of the publishing of the notification that the licence enabling the Insurer to carry on its insurance business has been withdrawn.
6. If the policyholder or the insured person breaches, whether intentionally or through negligence, the duty stipulated in paragraph 1 or 2 of Article 17 of this section, the insurer shall be entitled to withdraw from the insurance policy if it can prove that it would not have concluded the insurance policy had the questions been answered truthfully and completely. The policyholder shall be entitled to withdraw from the insurance policy if the insurer breached the duty stipulated in paragraph 7 or 8 of Article 14 of this section. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that this party had learned or ought to have learned of a breach of the duty stipulated in paragraph 1 or 2 of Article 17 or in paragraph 7 or 8 of Article 14 of this section.
7. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the policy.
8. The insurance policy may, in exceptional cases, be terminated by a written agreement of the contracting parties under the agreed conditions.
9. The insurance policy may be assigned only with the Insurer's consent.
10. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder on the date of the Policyholder's death or the date of it being wound up without a legal successor; however, if the Insured Person gives written notice to the Insurer within thirty days of the Policyholder's death or winding up that he/she is not interested in the Insurance, the Insurance shall expire on the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his entry into the Insurance.
    However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.
11. If the Insurer issues the Policyholder with a notice reminding it to pay the premium and, as part of this reminder notice, and instructs the Policyholder that the Insurance shall expire if the premium is not paid during the additional period, the Insurance shall expire upon the futile passing of this period.
12. The insurance policy terminates upon the expiry of the insurance of all persons.

Art. 13

Premium

1. The Premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer and is stated in the insurance policy.
2. The premium is paid as a Single Premium, unless otherwise stated in the policy.
3. The payment of premiums in instalments can be agreed in the insurance policy. If an arrangement for the payment of premiums in instalments has been made and the policyholder fails to pay an instalment, the insurer shall be entitled to the entire insurance premium. The maturity of the entire premium occurs on the day following the due date of the premium instalment, with which the policyholder is in payment default.
4. The Premium is payable on the first day of the insurance period in the currency and the amount stated in the insurance policy.
5. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.
6. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the insurance policy is concluded.
7. If the Insurance is terminated as a consequence of an Insured Event, the Insurer shall be entitled to the Premium up to the end of the insurance period in which the insured event occurred.
8. If the insurance policy is terminated **by agreement** before the date of the 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 verifying the validity of the Insurance.
9. The Insurer is entitled to the premium until the time it learned of the expiry of the insurable interest.
10. If the Policyholder withdraws from the insurance policy, the Insurer shall return to the Policyholder the received premiums within 30 days of the date of the withdrawal taking effect less any Insurance Benefits it may have paid under the Insurance; if the Insurer withdraws from the insurance policy, it shall be entitled to also set off the costs associated with taking out and administering the Insurance. If the Insurer withdraws from the Insurance, the Policyholder, Insured Person or another party who had already received an Insurance Benefit shall reimburse the Insurer within this same time period the amount of the Insurance Benefit received that is surplus to the received premiums.
11. If the Policyholder withdraws from the insurance policy according to Article 12(7) of this section, the Insurer shall return to the Policyholder the received premiums without undue delay, but not later than 30 days from the date of the withdrawal taking effect; in so doing, the Insurer shall be entitled to deduct any Insurance Benefit it had already paid under the Insurance. However, if the amount of Insurance Benefit paid exceeds the amount of premiums received, the Policyholder, or the Insured Person or the beneficiary in the event of the Insured Person's death, as the case may be, shall be obliged to pay the Insurer the amount of the Insurance Benefit paid that is surplus to the premiums received.
12. The Insurer will set off its outstanding premiums in the order in which they were created rather than in the order in which reminder letters were sent.

Art. 14

Rights and Obligations of the Insurer

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports and/or to consult complicated Loss Events with healthcare providers (healthcare facilities) or other competent entities, even abroad.
2. The Insurer shall issue the Insurance Certificate to the Policyholder after the conclusion of the insurance policy and payment of the premium.
3. If the event of the loss, damage or destruction of a valid Insurance Certificate, the Insurer shall issue a duplicate thereof to the Policyholder at the Policyholder's request; the same applies to the issue of a copy of the insurance policy concluded in writing.
4. The Insurer shall notify the Interested Party information about the Insurer and the Insurance taken out prior to the conclusion of the insurance policy.
5. The Insurer is also obliged to accept the payment of outstanding premiums and other outstanding receivables under the Insurance from the Policyholder's pledgee, from a Beneficiary or from the Insured Person.
6. Within the Duration of the Insurance, the Insurer shall provide information to the Policyholder at his address stipulated in the insurance policy or via the Insurer's web site. If the correspondence address is different from the address of the registered

office or residential address, then it is designated as the correspondence address. The address may also be an address designated for electronic communication.

7. If the Insurer ought to be aware of the inconsistencies between the Insurance being offered and the Interested Party's requirements when concluding the insurance policy, it shall alert the Interested Party of them. In so doing, the circumstances and the manner in which the insurance policy is concluded, as well as whether the other contracting party is being assisted in the conclusion of the policy by an agent independent of the insurer shall be taken into account.
8. If the Insurer asks the Interested Party or the Policyholder in writing whilst negotiating the conclusion of the insurance policy about facts pertaining to the Insurance, the Insurer shall answer these questions truthfully and completely.
9. If the Policyholder asks the Insurer in writing to provide him with information that is material for rendering benefits under the policy, the Insurer shall provide such information in writing without undue delay.

Art. 15

Obligations of the Policyholder

The Policyholder has the following obligations:

1. To pay the Insurance premium to the Insurer in a timely manner.
2. To inform all Insured Persons, in a timely manner, of the contents of the insurance policy, including all annexes and parts thereof, and provide them with all materials and information which it has received on their behalf from the Insurer.
3. To inform the Insurer without undue delay of a change in correspondence address.
4. If the Policyholder is also the Insured Person, all the obligations of the Insured Person shall apply to the Policyholder as well.

Art. 16

Obligations of the Insured Person

The Insured Person has the following obligations:

1. To do everything to avert the occurrence of an Insured Event and to reduce the extent of their consequences,
2. To take all the necessary and reasonable steps to prevent the extent of the consequences of the Loss Event from increasing and to exclude actions that prevent or hinder healing (e.g. failure to observe the treatment regime, including follow-up examinations, failure to seek medical treatment in the case of the continuation, aggravation, or occurrence of new difficulties); the Insurer is entitled to refuse to pay the Insurance Benefit in the event that this obligation is not observed,
3. To release the healthcare provider in writing from its obligation to maintain confidentiality and provide the Insurer with written authorisation to obtain information from healthcare staff which is subject to the obligation to maintain confidentiality and which is required for the Insurer's investigations if any Loss Event has occurred,
4. To undergo treatment or necessary medical examinations by a doctor designated by the Insurer,
5. To always undergo medical treatment or check-up at a time designated by the attending doctor,
6. To always follow the instructions given by the attending doctor and to abide by the treatment regime prescribed by the attending doctor,
7. To observe safety regulations and measures for the period of the Insurance being in effect (e.g. to respect a warning given by a mountain rescue service, to use seat belts whilst in a motor vehicle, to not enter areas designated as being dangerous to human health, to not move around avalanche areas, etc.),
8. To use suitable protective aids and equipment required for the maximum safe performance of all activities performed (e.g. use of seat belts),
9. To have the appropriate valid licence for the performance of all activities carried out at the Place of Insurance,
10. To arrange for proper supervision or escort, should this be usual for the performed activity,
11. To refrain from standing in places designated as inappropriate by the organiser,
12. To comply with the legislation in force at the Place of insurance,
13. To seek out medical treatment, should the need arise,

Art. 17

Other Rights and Obligations of the Parties to the Insurance

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst negotiating the amendment of the insurance policy about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.
2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.
3. Should an event occur with which the person who considers him/herself to be a Beneficiary links his/her claim to an Insurance Benefit, he/she shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event; at the same time, he/she shall also submit to the Insurer the required documents (e.g. the Insured Person's medical documentation) and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have these duties.
4. The same notification may be made by any person with a legal interest in the Insurance Benefit.
5. The notification under paragraph 3 and 4 of this article shall be deemed as having been received after the Insurer:
   I.) was notified of the event via the Insurer's form, which has been duly completed (Notice of Loss Event),
   II.) was handed copies (unless otherwise stipulated below) of all the required documents or documents requested by the Insurer, particularly:
      a) received the Insured Person's medical documentation,
      b) received, for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,
      c) received a copy of the discharge report
6. Handover of documents to the insurer is deemed to constitute consent with the insurer reviewing the medical state.
7. The parties to the Insurance submit copies of documents to the Insurer, or originals upon the Insurer's request.
   All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.
8. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit; at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.
9. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed therein, the Insurer shall be entitled to compensation for the costs it purposefully incurred in investigating the facts in regards to which this information was given to or concealed from him. It is understood that the demonstrable costs of the Insurer were incurred purposefully.
10. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.
11. The Policyholder and the Insured Person are obliged:
    a) to notify the Insurer in writing at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy,
    b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required,
    c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Peril.
12. The parties to the Insurance must not assign a claim for Insurance Benefit under the Insurance without the Insurer's consent.

Art. 18

Delivery of Documents

1. Correspondence delivered via the holder of a postal licence (hereinafter the "post office") shall be sent:
   a) to the Insurer at the address of the registered office stated in the insurance policy, or another address that is communicated to the Policyholder by the Insurer;
   b) by the Insurer to the correspondence address of the relevant person (addressee) stated in the insurance policy or otherwise notified to the Insurer. If the correspondence address is not stated in the insurance policy or subsequently notified to the Insurer, the correspondence will be sent to the address stated in the policy or notified to the Insurer as the residence or permanent residence, or the registered office of such a person.
2. Unless agreed otherwise, correspondence may also be delivered electronically (for example, via a data box, the Insurer's internet app, by e-mail) to the contact information provided for the purpose of electronic communication. Correspondence sent by the Insurer electronically to the last contact address provided by the addressee shall be deemed as delivered on the third business day after its sending, if the date of its delivery cannot be ascertained or if the relevant legal regulations do not stipulate otherwise.
3. Correspondence may also be delivered by an employee of the Insurer or another person authorised by the Insurer, especially to the addresses pursuant to paragraph 1 b), but also to any other place where the addressee will be willing to accept the correspondence. The correspondence thus delivered shall be deemed as delivered on the day of its receipt.

4. The parties to the Insurance are obliged to notify the Insurer without undue delay of any change in the facts relevant to the delivery and to notify each other of their new postal address, e-mail address or data box or telephone number.
5. If not a case of the delivery pursuant to paragraphs 6 to 8, correspondence sent by the Insurer by registered post with an advice of delivery shall be deemed as delivered on the day specified as the day of receipt of the correspondence on the advice of delivery, with correspondence sent by the Insurer by registered post without an advice of delivery, or sent by regular mail, being deemed as delivered on the third business day after dispatch, and in the case of delivery to an address in a country other than the Czech Republic, on the 15th business day after dispatch.
6. If the addressee deliberately thwarts the delivery of correspondence, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.
7. If the addressee thwarts the delivery of correspondence by failing to take delivery of the correspondence.
8. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence or by failing to mark his/her/its letter box by his/her first name and surname or company name, it shall be deemed to have been duly delivered on the date on which it was returned to the insurer.
9. Correspondence sent by the Insurer by registered post or registered post with an advice of delivery shall be deemed duly delivered even in the case that they are received by another person in place of the addressee (e.g. a family member), to whom the post office delivered the correspondence in accordance with the legal regulations pertaining to postal services.

Art. 19

Form of Legal Acts

1. The insurance policy must be concluded in writing, unless the Civil Code provides otherwise.
2. In the event that the Policyholder's acceptance of the offer is found to be invalid due to a failure to accept the offer in writing or for any other reason, and the Policyholder pays the first premium or an instalment thereof in the amount and within the time period specified in the offer (if no time period is stated in the offer, then within one month of the delivery of the offer), the offer shall be deemed to have been received by virtue of the payment of this first premium or an instalment thereof.
3. Legal acts, notices, and requests must be made in writing if they have an effect on:
   a. the duration and termination of the insurance,
   b. changes in the premium,
   c. changes in the scope of the insurance.
4. A legal act, for which a written form is required, shall be valid, in particular, where it is personally signed by the acting person, or where the signature is replaced by a mechanical means, where this is usual, if made by means of a data box, if provided with a guaranteed electronic signature pursuant to a special law, or if it is made via the Insurer's protected internet client portal.
5. Legal acts, notices, and requests, not mentioned in paragraph 3. may be made in writing, over the telephone, by e-mail, via the Insurer's internet application or via a data box, if the Insurer permits delivery to a data box. This applies namely to the reporting of an Insured Event, notification by the Policyholder or the Insured Person pertaining to a change in the surname, residential address, correspondence address, and other contact details, as specified in the policy. Legal acts, notices, and requests pursuant to this paragraph, made other than in writing must be subsequently supplemented in written form, if the Insurer so requests.
6. The insurer is entitled, as regards matters relating to the insurance relationship, namely in connection with the administration of the Insurance and the settlement of Insured Events, to contact other parties to the Insurance by electronic or other technical means (e.g. via telephone, SMS, e-mail, fax, data box), unless agreed otherwise. In electing the form of communication, the Insurer shall take into account the obligations stipulated by the relevant legal regulations and the nature of the information communicated.
7. Legal acts, notices, and requests shall be effective against the other contracting party as soon as they have been received by this party.

Art. 20

Rescue Costs

1. If the Policyholder purposefully incurs costs in averting the immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, it shall be entitled to compensation for these costs from the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.
2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit. The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Insurer's consent.
3. Compensation for rescue costs is in excess of the framework of the Insurance Benefit limit.
4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Art. 21

Assignment of Rights to the Insurer

1. If a person entitled to the Insurance Benefit, the Insured or a person incurring rescue costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to this right against someone with whom he/she lives in a joint household or is dependent on him/her, unless he/she caused the Insured Event intentionally.
2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all that is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the Insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.
3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become stature-barred.
4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party if such claims pass to the Insurer.
5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.
6. If, in connection with the exercise of the claim, the Insurer incurs additional costs due to the fault of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs

Art. 22

Final Provisions

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.
2. The language of communication is Czech.
3. Persons with restricted legal capacity shall be represented by their guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.
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 costs associated with taking out and administering the insurance come to 20% of the unearned premium.
6. 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.