SPLOŠNI POGOJI ZA ZDRAVSTVENO ZAVAROVANJE OSEB V TUJINI Z ASISTENCO 01-ZZTA-01/13

Izrazi v teh pogojih pomenijo:

zavarovalec	-	oseba, ki sklene zavarovalno pogodbo;
zavarovanec	-	oseba, katere premoženjski interes je zavarovan in ki je navedena na polici;
upravičenec	-	oseba, ki je upravičena do zavarovalnine oz. povračila stroškov v primeru nastanka zavarovalnega primera;
zavarovalna pogodba	-	pogodba o zagotavljanju asistence, ki jo skleneta zavarovalec in zavarovalnica;
polica	-	listina o sklenjeni zavarovalni pogodbi za zdravstveno zavarovanje oseb v tujini z asistenco, ki jo je izdala zavarovalnica zavarovancu, ki potuje v tujino;
premija	-	znesek, ki ga zavarovalec plača zavarovalnici po zavarovalni pogodbi;
zavarovalnina	-	znesek, ki ga zavarovalnica plača v okviru določil zavarovalne pogodbe zavarovancu;
zavarovalni primer	-	dogodek, ki ga krije to zavarovanje in nastopi v obdobju trajanja tega zavarovanja;
asistenca	-	pomoč v primeru bolezni ali telesne poškodbe v času nahajanja v tujini;
asistenčna družba	-	Assistance CORIS, d.o.o., Ul. bratov Babnik 10, 1000 Ljubljana, Slovenija;
tujina	-	področje, kjer zavarovalnica zavarovancu v skladu z zavarovalno pogodbo nudi zavarovalno kritje. Za tujino se ne šteje država, kjer ima zavarovanec stalno oziroma začasno bivališče;
država stalnega bivališča	-	država, kjer ima zavarovanec stalno oziroma začasno uradno bivališče;

1. člen ZAVAROVANE OSEBE

(1) Pri **posameznem zavarovanju** je zavarovanec oseba, ki je navedena na polici.
(2) Pri **družinskem zavarovanju** so zavarovanci osebe, ki so navedene na polici in živijo v skupnem gospodinjstvu ter so med seboj v družinskem razmerju: zakonec ali partner iz druge pravno priznane skupnosti in njihovi otroci, pastorki ali posvojenci do 26. leta starosti.
(3) Pri **skupinskem zavarovanju** so zavarovanci vse osebe, ki so navedene na polici oziroma v prilogi k polici in ki predstavljajo skupino. Skupina pomeni 9 ali več oseb. Če je manj kot 9 oseb, se uporabljajo določila za posamezno zavarovanje, če ni drugače dogovorjeno.
(4) Zavarovanci po teh pogojih so lahko le osebe stare do dopolnjenega 75. leta starosti. Zavarujejo se lahko tudi osebe starejše od 75 let z ustreznim doplačilom na premijo.
(5) Zavarovalec ne more biti oseba, ki ji je v celoti odvzeta popolna poslovna sposobnost in duševno motena oseba.

2. člen ZAČETEK IN TRAJANJE ZAVAROVANJA

(1) Zavarovalno kritje se začne ob 00.00 uri tistega dne, ki je v polici naveden kot začetek zavarovanja, če je do takrat plačana premija. Če premija do tedaj ni plačana, se začne zavarovalno kritje ob 00.00 naslednjega dne, ko je plačana.
(2) Zavarovalno kritje preneha ob 24.00 uri tistega dne, ki je v polici naveden kot dan prenehanja zavarovanja.
(3) Pri celoletnem zavarovanju za večkratne odhode zavarovanca v tujino zavarovanje velja za neomejeno število odhodov v tujino v enem zavarovalnem letu, s tem, da posamezno zadrževanje v tujini ne sme trajati več kot 90 dni.

3. člen KRAJ ZAVAROVANJA

Zavarovalno kritje je veljavno samo v tujini – to je izven območja države, kjer ima zavarovanec prijavljeno stalno oziroma začasno bivališče.

4. člen IZKLJUČITEV OBVEZNOSTI ZAVAROVALNICE

(1) V celoti so izključene vse obveznosti zavarovalnice, če je primer nastal, kot posledica:
1. potresa;
2. vojne v državi, notranjih nemirov in vstaj;
3. samomora ali poskusa samomora ali naklepne samopoškodbe;
4. vožnje motornih in drugih vozil brez ustreznih uradnih dovoljenj;
5. ravnanja zavarovanca pod vplivom alkohola, drog ali zdravil;

6. namernega ali naklepnega kaznivega dejanja;
7. javnih shodov, zborovanja ob aktivni udeležbi zavarovanca;
8. radioaktivnih sevanj, epidemije, pandemije.

(2) Zdravstveno zavarovanje tudi ne nudi asistence in ne krije stroškov za dogodke, ki nastanejo kot posledica:
1. priprave ali udeležbe:
   - na avto-moto tekmovanjih, pri vožnjah po dirkališčih in pripadajočih treningih ter rekreativni udeležbi;
   - v športnem letalstvu, padalstvu, pri letenju z zmaji, z jadralnimi letali;
   - pri alpinizmu;
   - pri smučanju in deskanju na snegu izven urejenih smučišč;
   - pri jamarstvu;
2. rekreativne udeležbe:
   - pri planinarjenju in trekingu nad 3.000 metrov nadmorske višine, če to v polici ni posebej dogovorjeno;
   - pri potapljanju in podvodnem ribolovu, če to v polici ni posebej dogovorjeno;
   - pri kajtanju (kitesurfing, kiteboarding) ali heliskiingu, če to v polici ni posebej dogovorjeno;
   - pri prostem plezanju, če to v polici ni posebej dogovorjeno;
   - na drugih športnih tekmovanjih in treningih, če to v polici ni posebej dogovorjeno;
3. izvajanja ekstremnega športa ali so v neposredni zvezi s še posebej nevarno dejavnostjo, če je le ta povezana z nevarnostjo, ki precej presega običajno tveganje pri nahajanju v tujini;
4. nastopa na ekspedicijah v neosvojena ali neraziskana področja;
5. vseh kroničnih bolezni ter ostalih bolezni ponavljajočega se značaja oziroma poslabšanja že obstoječih ali ponavljajočih se bolezni, zaradi katerih je zavarovanec že bil zdravljen ali so se pojavile in niso bile v celoti odpravljene pred odhodom v tujino;
6. ponavljajočih izvinov in izpahov ter zdravljenja poškodb, ki so nastale pred začetkom trajanja zdravstvenega zavarovanja;
7. poškodb, ki jih utrpijo osebe, katerim v skladu s 1. členom teh pogojev ni dovoljeno skleniti zavarovanje;
8. prevoza za težave, ki se lahko zdravijo na kraju škodnega dogodka;
9. zdravljenja, ki ga nudi oseba s katero zavarovanec potuje;
10. psihičnih motenj;
11. nalezljivih spolnih bolezni;
12. nosečnosti, rednih pregledov v času nosečnosti, tipičnih težav v času nosečnosti ter poroda, razen v primeru reševanja življenja matere oziroma otroka;
13. prekinitve nosečnosti;
14. zobozdravstvenih storitev, razen nujne zobozdravstvene pomoči, ki je potrebna za odpravo akutne bolečine zaradi bolezni ali sveže poškodbe zobovja, vključno z ekstrakcijo zoba, do zneska v preglednici kritij navedeni na koncu teh pogojev;
15. posebne storitve v bolnišnici - nadstandard, kot je enopostelja soba, TV, posebne nastanitve, itn.;
16. telefonski stroški, razen nujnih klicev na klicni center asistenčne družbe;
17. operacije ali zdravljenja, katerega se lahko prestavi brez kakršnihkoli posledic na čas povratka v državo stalnega bivališča zavarovanca;
18. nezgode pri profesionalnem fizičnem delu, če to v polici ni posebej dogovorjeno.

(3) Zavarovalnica ne krije stroškov v naslednjih primerih:
1. če zavarovanec ne obvesti zavarovalnice ali njenih predstavnikov o nastanku zavarovalnega primera, telefonsko ali pisno, v roku 3 dni od začetka bolezni ali poškodbe;
2. če ne spoštuje drugih navodil za uveljavljanje pravic iz zdravstvenega zavarovanja v primeru bolezni ali nezgode;
3. če se na zahtevo zavarovalnice ne pusti pregledati zdravniku, ki ga imenuje zavarovalnica ali njeni predstavniki.

(4) Izključene so vse obveznosti zavarovalnice v primeru dajanja neresničnih podatkov zavarovalca oziroma zavarovanca o trajanju zadrževanja v tujini, o okoliščinah poškodbe ali vrsti bolezni ter kakršnihkoli prevar ali ponaredb.

(5) Ne glede na druge določbe te zavarovalne pogodbe s tem zavarovanjem ni krita škoda, ki je nastala v neposredni ali posredni povezavi s terorističnim dejanjem, niti katerikoli stroški, ki so nastali kot posledica škode, in sicer niti v primeru, če je skupaj s terorističnim dejanjem na nastanek škode vplival še kak drug vzrok ali dejanje. Šteje se, da je teroristično dejanje vsako nasilno dejanje ali dejanje, ki ogroža človeško življenje, premično oziroma nepremično premoženje ali infrastrukturo, in sicer s silo, nasiljem ali grožnjo in je izvedeno zaradi političnih, verskih, ideoloških ali podobnih namenov ter ima namen vplivati ali vpliva na vlado kakšne države ali ima namen ustrahovati ali ustrahuje javnost oziroma katerikoli njen del. Za teroristično dejanje se šteje tako dejanje, ki je izvedeno samostojno, kakor tudi tisto, ki je izvedeno v povezavi s katerokoli organizacijo ali oblastjo. Iz kritja so izključeni tudi škoda in stroški, nastali zaradi preprečevanja oziroma zatiranja terorističnih dejanj.

5. člen VELJAVNOST ZAVAROVANJA

(1) Zavarovalna pogodba je sklenjena, ko pogodbenika podpišeta zavarovalno polico ali potrdilo o kritju.

(2) V primeru sklepanja na daljavo je zavarovalna pogodba sklenjena s samim plačilom premije, kar zavarovalec dokazuje s potrdilom o plačilu premije.
(3) Zavarovanje je potrebno skleniti v času, ko se zavarovanec nahaja v Republiki Sloveniji. Če se ob sklenitvi zavarovanec nahaja v tujini, zavarovalno kritje po teh pogojih prične veljati šele po preteku 5 dni od dneva sklenitve zavarovanja.
(4) Če ni drugače dogovorjeno, učinkuje zavarovalna pogodba od štiriindvajsete ure dneva, ki je v polici označen kot dan začetka zavarovanja, pa vse do konca zadnjega dneva, za katerega je zavarovanje sklenjeno.
(5) Če je dogovorjeno, da je treba premijo plačati:
   1) ob sklenitvi pogodbe in premija ni bila plačana, začne teči obveznost zavarovalnice, da izplača v pogodbi določeno zavarovalnino, ob 24. uri dne, ko je premija plačana;
   2) po sklenitvi pogodbe, začne teči obveznost zavarovalnice, da izplača v pogodbi določeno zavarovalnino, na dan, ki je v pogodbi določen kot dan začetka zavarovanja.
(6) Zavarovanje je možno obnoviti najkasneje 5 dni pred iztekom tekočega zavarovalnega obdobja. Če se zavarovanje obnovi po izteku omenjenega roka, v prvih 5 dnevih obnovljenega zavarovanja ni zavarovalnega kritja za primer bolezni (karenca). Karenca se ne upošteva, če se zavarovanec ob obnovitvi nahaja v Republiki Sloveniji.

6. člen OBSEG KRITJA

(1) Zavarovalnica nudi asistenco in krije nujne stroške zdravljenja, stroške prevoza zavarovanca, ki so nastali v času nahajanja v tujini, razen v primerih, navedenih v 4. členu teh pogojev.
(2) Asistenca klicnega centra asistenčne družbe obsega 24 ur na dan in 7 dni v tednu:
   - organizacijo nujne zdravstvene pomoči,
   - organizacijo nujnih zdravstvenih prevozov zavarovanca,
   - obveščanje zavarovanca in njegovih najbližjih,
   - telefonske stroške na klicni center asistenčne družbe.
(3) Nujni stroški zdravljenja obsegajo:
   - stroške medicinske oskrbe, obiska zdravnika, vključno z zdravili in zdravniškimi pripomočki izdanimi na zdravniški recept ali predpisanimi na zdravniškem izvidu,
   - stroške zdravljenja do dne, ko zdravstveno stanje zavarovanca le temu dovoljuje prevoz v državo stalnega prebivališča, kjer bo nadaljeval z zdravljenjem,
   - nujno zobozdravstveno pomoč, ki je potrebna za odpravo akutne bolečine zaradi bolezni ali sveže poškodbe zobovja, vključno z ekstrakcijo zoba, do zneska v preglednici kritij navedeni na koncu teh pogojev.
(4) Stroški prevoza obsegajo:
   - stroške prevoza zavarovanca do najbližje bolnišnice ali klinike in nazaj do mesta nahajanja v tujini,
   - stroške prevoza obolelega ali poškodovanega zavarovanca v domovino s predhodnim soglasjem asistenčne družbe, če se zavarovanec iz zdravstvenih razlogov ne more vrniti v domovino na način, kot je to prvotno nameraval,
   - stroške posmrtnih ostankov zavarovanca v domovino.
(5) Dodatne stroške prevoza in stroške bivanja za osebo, ki na zahtevo oziroma po priporočilu lečečega zdravnika ostane v spremstvu zavarovanca, oziroma stroške prevoza ožjega sorodnika iz domovine do kraja hospitalizacije, če zavarovancu ni mogoče zagotoviti drugačnega spremstva. V primerih, ko je zavarovanec mladoletna oseba se krijejo dodatni stroški prevoza in stroški bivanja za osebo, ki ostane v spremstvu zavarovanca ne glede na to ali je spremstvo priporočil lečeči zdravnik.
(6) Stroške prevoza zavarovančevega otroka, mlajšega od 18 let, do stalnega bivališča, kot tudi stroške prevoza njegovega spremljevalca v primeru zavarovančeve hospitalizacije ali smrti.
(7) Stroški, navedeni v 5. in 6. odstavku tega člena, se ne vrnejo brez predhodnega soglasja klicnega centra CORIS.
(8) Stroški organizacije nujne vrnitve v domovino v izrednih primerih (težja bolezen ali smrt družinskega člana v domovini). Kriti so stroški prestavitve letalske karte oz. povratnega rednega poleta (ekonomski razred), če prestavitev ni možna ali vožnje z vlakom (1. razred) zavarovanca v domovini.
(9) Stroški obiska zavarovanca. Stroški povratne vozovnice za javni prevoz (ekonomski razred) za enega družinskega člana, če se zavarovanec iz zdravstvenih razlogov ne more vrniti v domovino in je hospitaliziran več kot 7 dni iz razlogov kritih po teh pogojih.
(10) Za nujne stroške se štejejo stroški za storitve, ki so nujno potrebne za ohranjanje življenjskih funkcij ali preprečitev hudega poslabšanja zdravstvenega stanja nenadno obolelega ali poškodovanega zavarovanca.
(11) Skupni znesek nujnih stroškov zdravljenja in stroškov prevoza na osebo, če so le-ti z medicinskega stališča upravičeni ter stroškov, navedenih v 5. in 6. odstavku tega člena, za vse zavarovalne primere, ki nastanejo v času trajanja zdravstvenega zavarovanja, ne sme presegati zneska v preglednici kritij navedeni na koncu teh pogojev.

7. člen NEVARNOSTNE OKOLIŠČINE

(1) Pred sklenitvijo kakor tudi med trajanjem zavarovalne pogodbe mora zavarovalec prijaviti zavarovalnici vse okoliščine, ki so pomembne za ocenitev nevarnosti in so mu bile znane ali mu niso mogle ostati neznane. Za okoliščine, ki so pomembne za ocenitev nevarnosti,

štejejo zlasti okoliščine, ki so zavarovalcu znane in na podlagi katerih je določena in obračunana premija, kakor tudi one, ki so navedene v zavarovalni pogodbi. Te okoliščine lahko zavarovalec in zavarovalnica določita tudi skupaj.

(2) Zavarovalec mora omogočiti zavarovalnici pregled in oceno nevarnosti.

8. člen DOLŽNOSTI ZAVAROVANCA PO ZAVAROVALNEM PRIMERU

(1) Po nastanku zavarovalnega primera mora zavarovanec takoj storiti vse, kar je v njegovi moči, da bi preprečil nadaljnje nastajanje škode, upoštevajoč pri tem navodila asistenčne družbe in poskušati omejiti stroške po svojih najboljših močeh.

(2) Zavarovanec mora obvestiti zavarovalnico o nastanku zavarovalnega primera najkasneje v treh dneh od dneva, ko zanj izve.

(3) Zavarovanec mora dati zavarovalnici vse podatke in druge dokaze, ki jih ima na voljo in so nujno potrebni za ugotavljanje vzroka, obsega in višine škode ter organizacijo asistence. V vsakem primeru mora zavarovanec ravnati po navodilih, ki jih dobi od zavarovalnice ali od njenih predstavnikov.

(4) Dokumentacija, ki jo zavarovanec dostavi je naslednja:

a) v primeru bolezni:
   - zdravstvena dokumentacija, ki opravičuje nujnost zdravljenja ter dokumentacija navedena pod točko c),

b) v primeru nezgode:
   - zdravstvena dokumentacija,
   - uradna poročila ali potrdila, napisanega v tujini na podlagi okoliščin nesreče oziroma poškodbe ter dokumentacija navedena pod točko c),

c) v obeh primerih:
   - kopija zavarovalne police,
   - originalni račun stroškov tuje zdravstvene pomoči,
   - originalni račun za zdravila in prevoze,
   - uradni prevod dokumentacije na zahtevo zavarovalnice,
   - dodatne dokumentacije na zahtevo zavarovalnice.

(5) Če zavarovanec svojih obveznosti iz tega člena v dogovorjenem roku ne izpolni, zavarovalnica lahko odkloni plačilo zavarovalnine, če zaradi te opustitve ne more ugotoviti nastanka zavarovalnega primera.

(6) Če zavarovanec po svoji krivdi zavarovalnici ne prijavi nastanka zavarovalnega primera v času in na način, ki je določen s temi pogoji, mora zavarovalnici povrniti morebitno škodo, ki jo le-ta ima zaradi tega.

(7) Če zavarovanec ni uporabil zdravstvene asistence in je nujne zdravstvene storitve plačal sam, mu zavarovalnica povrne stroške skladno s 6. členom teh pogojev po predložitvi zahtevane dokumentacije.

9. člen DOLŽNOSTI ZAVAROVALNICE PO ZAVAROVALNEM PRIMERU

(1) Če nastane zavarovalni primer, mora zavarovalnica izplačati zavarovalnino v roku štirinajst dni, šteto od dneva, ko razpolaga z vso dokumentacijo, na podlagi katere lahko odloča o temelju in višini zahtevka. Če znesek njene obveznosti ni ugotovljen v tem roku, mora zavarovalnica zavarovancu oziroma upravičencu na njegovo zahtevo izplačati nesporni del svoje obveznosti kot predujem.

(2) Zavarovalnica plača ob vsakem zavarovalnem primeru obračunano škodo v celoti, vendar največ do zneska v preglednici kritij navedeni na koncu teh pogojev.

10. člen PRAVICE ZAVAROVALNICE

(1) V primeru nezgode, ki jo povzroči tretja oseba, ima zavarovalnica pravico do povračila stroškov, ki jih je plačal zavarovancu, od povzročitelja nezgode.

(2) Zavarovalnica si pridržuje pravico do regresa vseh nastalih stroškov v primeru, ko se naknadno ugotovi, da je zavarovalni primer nastal zaradi kronične bolezni, čezmernega uživanja alkohola ali zdravil in drugo, navedeno v 6. členu.

11. člen PLAČILO PREMIJE IN POSLEDICE NEPLAČILA PREMIJE

(1) Premijo za prvo zavarovalno leto mora zavarovalec plačati ob sklenitvi pogodbe, premije za naslednja zavarovalna leta pa prvi dan vsakega nadaljnjega zavarovalnega leta. Če je dogovorjeno, da se premija plačuje v obrokih, mora biti prvi obrok vplačan ob sklenitvi pogodbe, razen če ni drugače dogovorjeno. Ob nastanku zavarovalnega primera ima zavarovalnica pravico zahtevati takojšnje plačilo vseh obrokov premije za zavarovalno leto.

(2) Če je dogovorjeno, da se premija plačuje v obrokih ali za nazaj, se lahko obračunajo redne obresti od zneska premije, za katero je dogovorjena odložitev plačila. Če obrok ni plačan do dneva zapadlosti, ima zavarovalnica pravico do zakonskih zamudnih obresti in pravico zahtevati takojšnje plačilo vseh še nezapadlih obrokov.

(3) Če je premija plačana po pošti ali banki, velja za čas plačila dan, ko je bil dan nalog za plačilo pošti ali banki. V primeru, da ob

plačevanju premije ni naveden točen sklic, iz katerega bi bilo razvidno, katera premija oziroma kateri obrok premije in po kateri zavarovalni pogodbi se plačuje, se šteje, da se plačuje tista neplačana premija oziroma tisti obrok premije, ki je po dnevu zapadlosti najstarejši in sicer ne glede na vrsto zavarovalne pogodbe, ki je sklenjena pri zavarovalnici.

(4) Če je bil glede na dogovorjeni čas zavarovanja priznan popust na premijo, zavarovanje pa je prenehalo pred potekom tega časa, lahko zavarovalnica terja razliko do tiste premije, ki bi jo moral zavarovalec plačati, če bi se bila pogodba sklenila le za toliko časa, kolikor je dejansko trajala.

(5) V primeru prenehanja zavarovalne pogodbe zaradi neplačane zapadle premije, mora zavarovalec plačati premijo za čas do dneva prenehanja pogodbe ali celotno premijo za tekoče zavarovalno leto, če je do dneva prenehanja veljavnosti pogodbe nastal zavarovalni primer, za katerega mora zavarovalnica plačati zavarovalnino. Zavarovalec je dolžan povrniti tudi popust na premijo, ki mu je bil priznan za dogovorjeni čas zavarovanja, kot je opredeljeno v prejšnjem odstavku.

(6) Zavarovalnica ima pravico, da ob kakršnem koli izplačilu iz zavarovanja od zavarovalnine odtegne vse zapadle in neplačane premije tekočega zavarovalnega leta kakor tudi druge zapadle obveznosti zavarovalca do zavarovalnice iz preteklih let.

(7) Obveznost zavarovalnice, da izplača zavarovalnino preneha v primeru, če zavarovalec do zapadlosti ne plača premije, ki je zapadla po sklenitvi pogodbe, in tega tudi ne stori kdo drug, ki je za to zainteresiran, po tridesetih dneh od dneva, ko je bilo zavarovalcu vročeno priporočeno pismo zavarovalnice z obvestilom o zapadlosti premije, pri čemer pa ta rok ne more izteči prej, preden ne preteče trideset dni od zapadlosti premije.

(8) Zavarovalnica lahko po izteku roka iz 7. odstavka tega člena, če je zavarovalec v zamudi s plačilom premije, ki jo je treba plačati po sklenitvi pogodbe oziroma druge in naslednjih premij, razdre zavarovalno pogodbo brez odpovednega roka, s tem da razdrtje zavarovalne pogodbe nastopi z iztekom roka iz 7. odstavka tega člena in s prenehanjem zavarovalnega kritja, če je bil zavarovalec na to opozorjen v priporočenem pismu z obvestilom o zapadlosti premije in o prenehanju zavarovalnega kritja.

(9) Če zavarovalec, v primerih ko zavarovalnica ni razdrla zavarovalne pogodbe, plača premijo po izteku roka iz 7. odstavka tega člena, vendar v enem letu od zapadlosti premije, je zavarovalnica dolžna, če nastane zavarovalni primer, plačati zavarovalnino od 24. ure po plačani premiji in zamudnih obresti. Če zavarovalec premije v tem roku ne plača, zavarovalna pogodba preneha veljati s potekom zavarovalnega leta.

12. člen ODPOVED POGODBE IN VRAČILO PREMIJE

(1) Zavarovalec lahko odpove zavarovalno pogodbo v času, ko zavarovalno kritje še ni nastopilo - pred začetkom zavarovanja kot navedeno v polici.

(2) Odpoved zavarovalne pogodbe je možna le v primeru, če odhod v tujino odpade zaradi smrti ali bolezni zavarovanca ali ožjega družinskega člana. Odpoved v nobenem primeru ni možna po začetku zavarovalnega kritja.

(3) V primeru odpovedi zavarovalne pogodbe zavarovalnica vrne 85% plačane premije.

(4) Če trajanje zavarovanja ni določeno v pogodbi oziroma, če je v zavarovalni pogodbi dogovorjen rok trajanja z možnostjo, da se pogodba podaljšuje za enako časovno obdobje, sme vsaka stranka od nje odstopiti z dnem zapadlosti premije, le da mora o tem pisno obvestiti drugo stranko najmanj 3 mesece pred zapadlostjo premije.

(5) Če je zavarovanje sklenjeno za več kot 3 leta, sme po preteku tega časa vsaka stranka z odpovednim rokom šestih mesecev odstopiti od pogodbe, s tem da to pisno sporoči drugi stranki.

(6) V primeru, če je bila zavarovalna pogodba sklenjena na daljavo (preko spleta, telefona ipd) in za zavarovalno obdobje daljše od 30 dni, lahko zavarovalec brez razloga zavarovalno pogodbo odpove vendar najkasneje 15 dni pred začetkom zavarovanja. V tem primeru zavarovalnica vrne celoten znesek vplačane premije. Odstop mora biti pisen in vložen na zavarovalnico do izteka roka, pri čemer se šteje, da je vložen v roku, če je do izteka roka priporočeno oddan na pošti. Zavarovalec nima pravice do odstopa od pogodbe po tem odstavku pri zavarovalnih pogodbah z veljavnostjo, krajšo od enega meseca.

13. člen IZVEDENSKI POSTOPEK

(1) Vsaka pogodbena stranka lahko zahteva, naj določena sporna dejstva ugotavljajo izvedenci.

(2) Vsaka stranka imenuje enega izvedenca izmed oseb, ki s strankami niso v delovnem ali sorodstvenem razmerju. Imenovana izvedenca pred začetkom dela imenujeta tretjega izvedenca, ki da svoje mnenje le, kadar so ugotovitve prvih dveh izvedencev različne in le v mejah njunih ugotovitev.

(3) Vsaka stranka nosi stroške za izvedenca, ki ga je imenovala, za tretjega izvedenca nosi vsaka stranka polovico stroškov.

(4) Končne ugotovitve so obvezne za obe stranki.

14. člen SPREMEMBE ZAVAROVALNE POGODBE

(1) Če zavarovalnica spremeni zavarovalne pogoje ali premijski cenik, mora o spremembi zavarovalca pisno ali na drug primeren način obvestiti vsaj 60 dni pred potekom tekočega zavarovalnega leta.

(2) Zavarovalec ima pravico, da v 60-ih dneh po prejemu obvestila odpove zavarovalno pogodbo. Pogodba preneha veljati s potekom tekočega zavarovalnega leta.

(3) Če zavarovalec ne odpove zavarovalne pogodbe, se ta z začetkom prihodnjega leta spremeni v skladu z novimi zavarovalnimi pogoji ali premijskim cenikom.
(4) Zavarovalnica si pridržuje pravico popraviti morebitne zastopnikove računske ali druge napake, o čemer mora zavarovalnica zavarovalca pisno obvestiti. Zavarovalec ima pravico, da v primeru nestrinjanja s popravki (spremembami zavarovalne pogodbe s strani zavarovalnice) v roku 15 dni od prejema obvestila odstopi od zavarovalne pogodbe, pri čemer odpoved učinkuje za naprej. V primeru, če zavarovalec od zavarovalne pogodbe v tem roku ne odstopi, se šteje, da se s temi popravki/spremembami strinja, zato zavarovalna pogodba od izteka tega roka dalje velja z upoštevanimi popravki (spremembami zavarovalne pogodbe s strani zavarovalnice).

15. člen NAČIN OBVEŠČANJA

(1) Dogovori o vsebini zavarovalne pogodbe so veljavni le, če so sklenjeni v pisni obliki.
(2) Vsa obvestila in izjave, ki jih je treba dati po določbah zavarovalne pogodbe, morajo biti pisne.
(3) Obvestilo ali izjava je dana pravočasno, če se pošlje pred potekom roka s priporočenim pismom.
(4) Izjava, ki jo je treba dati drugemu, velja šele tedaj, ko jo ta prejme.

16. člen SPREMEMBA NASLOVA IN VROČANJE

(1) Zavarovalec mora obvestiti zavarovalnico o spremembi naslova svojega bivališča oziroma sedeža ali svojega imena oziroma firme v roku 15 dni od dneva spremembe.
(2) Če je zavarovalec spremenil naslov bivališča oziroma sedež ali svoje ime oziroma firmo, pa tega ni sporočil zavarovalnici, zadošča, da zavarovalnica obvestilo, ki ga mora sporočiti zavarovalcu, pošlje na naslov njegovega zadnjega znanega bivališča ali sedeža, ali ga naslovi na zadnje znano ime oziroma firmo.
(3) V primeru, da poskus vročitve priporočenega obvestila zavarovalcu ni bil uspešen (zaradi preselitve, odklonitve sprejema ipd.), zavarovalnica vrnjeno pošto šteje za vročeno in jo deponira na sedežu zavarovalnice. Zavarovalec se strinja, da se vrnjena nevročena priporočena pošiljka šteje za prejeto na dan prvega poizkusa vročitve ter da velja, da je zavarovalec z njeno vsebino seznanjen.
(4) V prejšnjem odstavku navedena domneva uspele vročitve ima na podlagi pogodbenega dogovora z zavarovalcem pravno veljavne učinke.

17. člen VARSTVO OSEBNIH PODATKOV

(1) Zavarovalec oziroma zavarovanec do preklica dovoljuje zavarovalnici in njenim pooblaščenim podjetjem za zastopanje in posredovanje zavarovanj, da v svojih zbirkah shranjujejo, obdelujejo in uporabljajo njegove osebne podatke, ki so potrebni za izvajanje zavarovanja in za namene obveščanja zavarovalca in zavarovanca o novostih in ponudbah s področja finančnih produktov.
(2) Zavarovanec pooblašča zavarovalnico in asistenčno družbo, da v njegovem imenu pridobi in vpogleda v zdravstveno dokumentacijo ter drugo dokumentacijo, ki je potrebna za ugotavljanje okoliščin za sklenitev zavarovanja in pri ugotavljanju obveznosti zavarovalnice.
(3) Zavarovalec dovoljuje zavarovalnici, da posreduje osebne podatke (osebno ime, naslov stalnega ali začasnega prebivališča, telefonsko številko, naslov elektronske pošte ter številko telefaksa) tudi drugim družbam, ki so z zavarovalnico v kapitalskih povezavah - t.j. vsem družbam, vključenim v KD Holding ter drugih z zavarovalnico povezanim odvisnim ali obvladujočim družbam. Le te lahko podatke uporabijo samo za namen neposrednega trženja, med drugim za namene obveščanja zavarovalca o novostih in ponudbah s področja finančnih produktov. Zavarovalec tudi dovoljuje, da zavarovalnica njune podatke pridobi od upravljavcev zbirk osebnih podatkov in jih posreduje biroju zelene karte ali drugemu organu, ki rešuje škodne primere.
(4) Zavarovalec oziroma zavarovanec lahko kadarkoli zahteva, da se preneha z uporabo njegovih osebnih podatkov za namen neposrednega trženja po prejšnjem odstavku. Zavarovalnica se obvezuje, da bo najkasneje v 15 dneh preprečila uporabo osebnih podatkov, za katero je bilo dano dovoljenje po prejšnjem odstavku tega člena.
(5) Zavarovalnica se obvezuje, da bo vse osebne podatke skrbno varovala v skladu z veljavno zakonodajo s področja varovanja osebnih podatkov.

18. člen REŠEVANJE SPOROV

(1) Zavarovalec, zavarovanec ali upravičenec lahko v 15 dneh po prejemu pisne odločitve zavarovalnice vloži pisno pritožbo na zavarovalnico, ki mora pritožbo obravnavati skladno z internim pravilnikom. Odločitev pritožbene komisije je dokončna in nadaljnji postopki pri zavarovalnici niso možni.
(2) V primeru nestrinjanja z dokončno odločitvijo zavarovalnice se lahko po posebnem dogovoru nadaljuje postopek za izvensodno rešitev spora pri Mediacijskem centru, ki deluje v okviru Slovenskega zavarovalnega združenja iz določenih razlogov pa tudi pred Varuhom dobrih poslovnih običajev v zavarovalništvu.
(3) Za razmerja iz zavarovalne pogodbe, ki niso urejena s temi pogoji, se uporablja slovensko pravo.
(4) V primeru sodnega spora je za reševanje pristojno sodišče v Kopru.
(5) Za izvajanje nadzora nad zavarovalnico je pristojna Agencija za zavarovalni nadzor, Trg republike 3, Ljubljana.

PREGLEDNICA ZAVAROVALNIH KRITIJ ZA ZDRAVSTVENO ZAVAROVANJE OSEB V TUJINI Z ASISTENCO

ZAVAROVALNA KRITJA				
Skupaj za vsa zavarovalna kritja največ do zavarovalne vsote:		**25.000 EUR** 20.000 EUR*	**50.000 EUR** 40.000 EUR*	**100.000 EUR** 60.000 EUR*
1.	**Nujni stroški medicinske oskrbe, obisk zdravnika**	√	√	√
2.	**Stroški zdravljenja**	√	√	√
3.	**Stroški prevoza do najbližje bolnišnice ali klinike in nazaj**	√	√	√
4.	**Prevoz v domovino**	√	√	√
5.	**Zdravila in zdravniški pripomočki**	√	√	√
6.	**Nujne zobozdravstvene storitve**	100 EUR	200 EUR	300 EUR
7.	**Stroški prevoza in bivanja za osebo, ki ostane v spremstvu zavarovanca**	√	√	√
8.	**Spremstvo in stroški prevoza mladoletnega otroka**	√	√	√
9.	**Prevoz družinskega člana**	vozovnica	vozovnica	vozovnica
10.	**Prevoz posmrtnih ostankov v domovino zavarovanca**	√	√	√
11.	**Povratek v primeru smrti družinskega člana**	√	√	√
	Starostna omejitev	75 let	75 let	75 let
	Starostna omejitev (potrebna dodatna premija)	85 let	85 let	85 let
	Starostna omejitev (potrebna dodatna premija)	nad 85 let	nad 85 let	nad 85 let
	Geografska veljavnost	cel svet	cel svet	cel svet
	√ - vključeno			

* Velja za zavarovanje oseb s stalnim bivališčem v tujini, ki začasno bivajo in delajo v RS.

GENERAL TERMS AND CONDITIONS OF TRAVEL HEALTH INSURANCE WITH ASSISTANCE ABROAD 01-ZZTA-01/13

TRANSLATION: Only the Slovene version shall be legally binding

The following terms contained in these General Terms and Conditions shall mean:

Policyholder	- The person who has concluded the insurance contract with the Insurance Company;
The Insured	- The person whose property interest is insured and who is stated in the policy;
Beneficiary	- The person who is entitled to the benefit – the reimbursement of costs – if an insured event occurs;
Insurance contract	- The contract on the provision of assistance, concluded by and between the Policyholder and the Insurance Company;
Policy	- A document proving the conclusion of the insurance contract for health insurance of persons abroad with assistance, issued by the Insurance Company to the Insured who is travelling abroad;
Premium	- A sum paid by the Policyholder to the Insurance Company under the insurance contract;
Benefit	- A sum paid by the Insurance Company to the Insured under the provisions of the insurance contract;
Insured event	- An event covered by this insurance and which occurs during the application period of this insurance;
Assistance	- aid in the event of illness or physical injury while being abroad;
Assistance Company	- Assistance CORIS, d.o.o., Ul. bratov Babnik 10, 1000 Ljubljana, Slovenia;
Abroad	- The territory where the Insurance Company offers insurance cover to the Insured in accordance with the insurance contract. Abroad shall not be any country where the Insured has a permanent or temporary residence;
Country of permanent residence	- The country of the Insured's permanent or temporary official residence;

Article 1 INSURED PERSONS

In **individual insurance** the Insured is the person stated in the policy.

(1) In **family insurance** the Insured are the persons who are stated in the policy and who live in shared household and are connected by family relationship: a spouse or partner from another legally recognised type of relationship, their children, stepchildren or adoptees until the age of 26 years.

(2) In **group insurance** the Insured are the persons who are stated in the policy or in the attachment to the policy and who form a group. A group consists of nine (9) or more persons. If there are less than nine (9) persons, the provisions for an individual insurance shall apply unless otherwise agreed.

(3) Under these Terms and Conditions the Insured can only be persons until their fulfilled 75th year of age. Persons older than 75 years may also be insured, but against additional premium payment.

(4) A person without contractual capability or a mentally ill person cannot be the Policyholder.

Article 2 COMMENCEMENT AND EXPIRATION OF INSURANCE

(1) The insurance cover shall start at 00:00 hrs of the day stated in the policy as the insurance commencement date, if the insurance premium has been paid until then. If the insurance premium has not been paid, the insurance cover shall start at 00:00 hrs of the next day when the premium has been paid.

(2) The insurance cover shall cease at 24:00 hrs of the day stated in the policy as the insurance termination day.

(3) If the insurance contract is concluded for one full year, the insurance shall apply for an unlimited number of the Insured's departures abroad in that year, provided that the Insured is not abroad more than 90 days each time.

Article 3 PLACE OF INSURANCE APPLICATION

The insurance cover shall only apply abroad, i.e. outside of the territory of the country where the Insured has a registered permanent or temporary residence.

Article 4 EXCLUSION OF INSURANCE COMPANY'S OBLIGATIONS

(1) The obligations of the Insurance Company shall be entirely excluded if an event has occurred as a result of:
1. an earthquake;
2. war events, riots or rebellions in the country;
3. a suicide or attempted suicide or self-inflicted injury;
4. driving motor vehicles or any other vehicles without holding appropriate official permits;
5. Insured's actions under the influence of alcohol, drugs or narcotics;
6. wilfully or intentionally committed criminal offence;
7. public assemblies or meetings where the Insured is actively engaged;
8. radiations, epidemics, or pandemics.

(2) The health insurance shall also not offer assistance or cover the costs for events occurred as a result of:
1. training or participation:
   - in any motor competitions as well as when driving on racecourses and the relevant trainings and recreational activities;
   - in sport aviation, parachuting, hang-gliding and gliding;
   - in mountain climbing;
   - in skiing and snowboarding outside of ski resorts;
   - in speleology;
2. recreational activities:
   - at mountaineering and trekking above 3,000 meters above sea level, unless expressly agreed in the insurance policy;
   - at diving and underwater fishing, unless expressly agreed in the insurance policy;
   - at kiting (kitesurfing, kiteboarding) or heliskiing, unless expressly agreed in the insurance policy;
   - at free climbing, unless especially agreed in the insurance policy;
   - at other sport competitions, unless especially agreed in the insurance policy;
3. doing an extreme sport or an activity in direct connection with a particularly dangerous activity, if it poses a risk that strongly exceeds an ordinary risk when being abroad;
4. attending expeditions or the yet unreached or unexplored areas;
5. any chronic disease and other diseases of recurrent nature or deterioration of existing or recurring diseases for which the Insured has already received treatment or which have occurred and were not entirely treated before the departure abroad;
6. repeated dislocations and sprains and the treatment of injuries which have occurred before the commencement of the health insurance;
7. injuries suffered by persons who are not allowed to take out the insurance pursuant to Article 1 of these Terms and Conditions;
8. transportation for problems that can be treated at the scene of the loss event;
9. treatment offered by a person travelling with the Insured;
10. mental disorders;
11. infectious sexual diseases;
12. pregnancy, routine physical examinations during pregnancy, typical complications during pregnancy and childbirth except for saving mother's or child's life;
13. induced abortion;
14. dental treatment except for urgent dental treatment, necessary for suppressing acute pain due to illness or fresh injury of teeth, including tooth extraction, up to the amount of coverage specified in the chart at the end of these terms and conditions;
15. special services in the hospital - higher standard, such as single room, TV, special accommodation, etc.;
16. cost of telephone conversations except emergency calls to the call centre of the Assistance Company;
17. operation or medical treatment, which can be postponed without any consequences to the time when the Insured will return to the country of his/her permanent residence;
18. accidents in professional physical work, unless expressly agreed in the insurance policy.

(3) The Insurance Company shall not cover costs in the following cases:
1. if the Insured does not inform the Insurance Company or its representatives, either by phone or letter, about the insured event at least five (5) days after the occurrence of sickness or injury;
2. if the Insured does not follow other instructions for asserting his/her rights from health insurance in case of illness or accident;
3. if on the Insurance Company's request the Insured does not accept medical examination by a doctor nominated by the Insurance Company or its representatives;

(4) All obligations of the Insurance Company will be excluded if the Policyholder or the Insured provides false data about the duration of a journey abroad, about the circumstances of an injury or the type of disease, as well as in the event of fraud or forgery.

(5) Notwithstanding the other provisions contained herein, this insurance shall not cover the loss which has occurred in connection, either direct or indirect, with an act of terrorism, or any costs which have occurred as a result of loss, even if an act of terrorism, which resulted in the occurrence of loss, was accompanied by another cause or act. An act of terrorism shall be any act of violence or an act

endangering human life, movable or immovable property or infrastructure, with force, violence, or threat, and which is performed for political, religious, ideological or similar intentions and which is intended to affect or which affects the government of any country, and which is intended to raise fear or which raises fear among the public or any of its parts. An act of terrorism shall be an act performed independently or in connection with any organisation or authority. Moreover, the insurance excludes the loss and costs, which have occurred for the purpose of preventing or suppressing acts of terrorism.

Article 5 APPLICATION OF INSURANCE

(1) The insurance contract shall be concluded when both contracting parties have signed the insurance policy or the cover note.
(2) In the case of remote conclusion of the insurance contract, the contract shall be concluded when the premium has been paid, which the Policyholder proves with the premium payment receipt.
(3) The insurance must be taken out while the Insured is in the Republic of Slovenia. If the Insured is outside of the territory of the Republic of Slovenia when the insurance contract is being concluded, the insurance cover under these Terms and Conditions shall only take effect after the end of five (5) days from the insurance commencement date.
(4) Unless otherwise agreed, the insurance contract shall take effect from 00:00 hrs of the day stated in the policy as the insurance commencement date, and it shall cease at the end of the last day stated as the termination date of insurance.
(5) If it has been agreed that the premium must be paid:
    1) upon the conclusion of the contract and the premium has not been paid, the liability of the Insurance Company to pay the benefit stated in the contract shall start at 00:00 hrs of the day when the premium is paid;
    2) after the contract is concluded, the liability of the Insurance Company to pay the benefit stated in the contract shall start on the day stated in the contract as the insurance commencement date.
(6) The insurance policy may be renewed five (5) days before the end of the current policy period at the latest. If the insurance is renewed after the end of the above-mentioned period, there will be no insurance cover for illness in the first five (5) days (deferment period). Deferment period shall not apply if the Insured is in the Republic of Slovenia when the insurance is being renewed.

Article 6 SCOPE OF COVER

(1) The Insurance Company shall offer assistance and cover the urgent medical treatment costs, and transportation costs for the Insured, which occurred while the Insured was abroad, except in cases stated in Article 4 of these Terms and Conditions.
(2) The assistance of the Assistance Company's call centre is available 24/7 and it covers:
    - the arrangement of urgent medical aid,
    - the arrangement of urgent medical transportation for the Insured,
    - informing the Insured and his/her closest family members,
    - telephone charges for calling the Assistance Company's call centre.
(3) Urgent medical costs include:
    - costs of medical treatment, doctor's visit, including prescription medications and medical supplies,
    - costs of hospitalisation until the day when the Insured's state of health permits him/her being transported to the country of permanent residence, where he/she shall continue the treatment,
    - urgent dental treatment which is necessary for suppressing acute pain due to illness or fresh injury of teeth, including tooth extraction, up to the amount of coverage specified in the chart at the end of these terms and conditions.
(4) Transportation costs include:
    - costs of transporting the Insured to the nearest hospital or clinic and back to the previous location abroad,
    - costs of transporting the sick or injured Insured to his/her homeland according to prior consent of Assistance Company, if the insured should for health reasons be unable to return to his/her homeland in the way as originally planned,
    - costs of transporting the Insured's mortal remains to his/her homeland.
(5) Additional transportation and accommodation costs for the person, who under request or according to recommendation of attending physician, remains in attendance of the Insured, or costs of transporting a close relative from the home country to the place of hospitalization, if no other type of escort can be provided to the Insured. If the Insured is a minor, additional costs of transportation and accommodation shall be covered for the person who remains in attendance of the Insured may it be recommended by the attending physician or not.
(6) The cost of transportation for an Insured's child aged under 18 years to the place of permanent residence, as well as the cost of transportation for the person accompanying the child in the event the Insured is hospitalized or dead.
(7) The costs referred to in the fifth and sixth paragraphs of this Article shall not be refunded without prior consent of the CORIS call centre.
(8) The cost of arranging the urgent return to the home country in exceptional cases (severe illness or death of a family member in the home country). The cost of changing the scheduled flight or a return regular flight (economy class) is covered, provided that the rescheduling is not possible, or the cost of train ticket (1st class) for the Insured to the Republic of Slovenia.
(9) The cost of visiting the Insured. The cost of return ticket for public transportation (economy class) for one family member, if the Insured is unable to return to the home country for medical reasons and is hospitalized for more than seven (7) days for reasons covered under

these Terms and Conditions.

(10) Urgent costs shall be costs for the services which are urgently necessary for the preservation of vital functions or for the prevention of severe deterioration of the suddenly diseased or injured Insured's medical condition.

(11) The total amount of the urgent medical treatment costs and costs of transportation per person, provided they are medically justified, and the costs referred to in the fifth and sixth paragraphs of this Article, for all insured events that occur in the period of the health insurance duration, may not exceed the amount specified in the chart at the end of these terms and conditions;

Article 7 RISK CIRCUMSTANCES

(1) Prior to concluding as well as throughout the duration of the insurance contract, the Policyholder shall be obliged to report to the Insurance Company any circumstances which are important to assess the risk and which he/she was aware of or could not prevent being unaware of. The circumstances important to assess the risk are in particular the circumstances known to the Policyholder and based on which the premium has been determined and accounted for, as well as those, which are stated in the insurance contract. The Policyholder and the Insurance Company may determine such circumstances together.

(2) The Policyholder shall enable the Insurance Company an overview and assessment of risk.

Article 8 OBLIGATIONS ATTACHING TO THE INSURED AFTER THE INSURED EVENT

(1) After the occurrence of an insured event, the Policyholder shall immediately do everything in his/her power to prevent any further loss by following the instructions of the Assistance Company, and trying to limit the costs to the best of his/her knowledge.

(2) The Insured shall inform the Insurance Company about the occurrence of an insured event at the latest within three days after the day when he/she has become aware of it.

(3) The Policyholder shall give to the Insurance Company all the data and other evidence, which are available to him/her and which are vital to establish the cause, volume and amount of loss as well as for the arrangement of assistance. In any case, the Insured shall obey the instructions provided by the Insurance Company or any of its representatives.

(4) The documentation, which the Insured must present, is:

a) In case of illness:
- medical records justifying the urgent nature of treatment and the documents stated under point c)

b) In case of accident:
- medical records,
- official reports or certificates written abroad based on the circumstances of the accident or injury, and the documents stated under point c),

c) In both cases:
- a copy of insurance policy,
- the original receipt of the costs of medical assistance abroad,
- the original receipt for medications and transportation,
- the official translation of documents on request of the Insurance Company,
- additional documents on request of the Insurance Company.

(5) The Insured's failure to fulfil his/her liabilities referred to in this Article within the agreed period of time may result in the Insurance Company's refusal to pay the benefit, if such failure makes the Insurance Company unable to establish the occurrence of the insured event.

(6) If the Insured fails to report the occurrence of the insured event at his/her fault in the time and the way as determined herein, he/she shall reimburse the Insurance Company for any loss it might have suffered in respect thereof.

(7) If the Insured did not use the medical assistance and paid the urgent medical services himself/herself, the Insurance Company shall reimburse him/her for the costs in accordance with Article 6 herein, upon presenting the required documentation.

Article 9 OBLIGATIONS ATTACHING TO THE INSURANCE COMPANY AFTER THE INSURED EVENT

(1) In case the insured event occurs, the Insurance Company shall pay the benefit within fourteen days starting from the date when it has received the entire documentation based on which it is able to establish the basis and the amount of the claim. If the sum of its liability is not established within this period, the Insurance Company shall pay, on the Insured's or Beneficiary's request, the incontestable part of its liability in form of advance payment.

(2) Upon each insured event, the Insurance Company shall pay the established loss in full, however not exceeding the amount of sums insured, which are determined in these Terms and Conditions.

Article 10 RIGHTS ATTACHING TO THE INSURANCE COMPANY

(1) In the event of an accident caused by a third party, the Insurance Company shall have the right to the reimbursement of costs paid to the Insured, from the person responsible for the accident.
(2) The Insurance Company reserves the right of recourse for all the costs occurred, if it is subsequently established that the insured event has resulted from chronic illness, excessive consumption of alcohol or narcotics or other, as referred to in Article 6 herein.

Article 11 PREMIUM PAYMENT AND CONSEQUENCES OF DEFAULT

(1) The Policyholder shall pay the premium for the first policy year upon the conclusion of the insurance contract, and the premiums for the following policy years on each first day of every subsequent policy year. If it is agreed that the premium be paid in instalments, the first instalment shall be paid upon the conclusion of the contract unless otherwise agreed. Upon the occurrence of an insured event, the Insurance Company shall have the right to demand immediate payment of all premium instalments for the current policy year.
(2) If it is agreed for the premium to be paid in instalments or retroactively, regular interest may be charged on the amount of premium for which the deferment of payment has been agreed. If an instalment is not paid by the maturity date, the Insurance Company shall have the right to charge legal default interest and to demand immediate payment of all non-past due instalments.
(3) If the premium is paid at a post office or bank, the date of payment shall be the day when the payment order was submitted at a post office or bank. If the reference is not clearly stated on the payment order, thus making it impossible to see which premium or which instalment of premium and which type of insurance contract is being paid for, it shall be considered that the default premium or the instalment of premium, which is the oldest by the maturity date, is being paid for, regardless of the type of insurance contract, which has been concluded with the Insurance Company.
(4) If a premium discount was agreed according to the agreed time of insurance, and the insurance terminated before the end of this time, the Insurance Company may collect the difference up to the premium which should be paid by the Policyholder were the contract concluded only for the period of time, which it actually lasted for.
(5) In case the insurance contract ends because of a default premium, the Policyholder shall pay the premium for the time until the contract termination date of the contract or the total premium for the current policy year, if the insured event for which the Insurance Company must pay the benefit has occurred by the termination date of the contract validity. The Policyholder shall also return the discount on the premium, which was awarded to him/her for the agreed duration of insurance, as determined in the previous paragraph.
(6) The Insurance Company has the right to deduct from the benefit all past due and default premiums of the current policy year as well as other default liabilities the Policyholder has to the Insurance Company from previous years.
(7) The liability of the Insurance Company to pay the benefit shall terminate if the Policyholder has not paid, by the maturity date, the premium which fell due after the conclusion of the contract, and if no interested party has done this after thirty days from the date when the Policyholder was served the registered letter of the Insurance Company with the notice on the premium maturity, whereby this period cannot end before the end of thirty days from the maturity of the premium.
(8) After the end of the deadline referred to in the seventh paragraph of this Article, the Insurance Company may rescind the insurance company without notice period, if the Policyholder is in default with the payment of the premium which must be paid after the conclusion of the contract or the second and subsequent premiums; the rescission of the contract shall take effect at the end of the deadline referred to in the seventh paragraph of this Article and with the end of the insurance cover, provided that the Policyholder was informed about this in the registered letter with the notice on the maturity of the premium and on the end of the insurance cover.
(9) If, in cases when the Insurance Company has not rescinded the insurance contract, the Policyholder pays the premium after the end of the deadline referred to in the seventh paragraph of this Article within one year after the maturity of the premium, the Insurance Company shall be obliged, in case the insured event occurs, to pay the benefit from 24:00 hrs after the premium and default interest have been paid. If the Policyholder does not pay the premium within this period of time, the insurance contract will end with the end of the policy year.

Article 12 CONTRACT CANCELLATION AND PREMIUM RETURN

(1) The Policyholder may cancel the insurance contract when the insurance cover has not yet begun, i.e. before the insurance commencement, as stated in the policy.
(2) The insurance contract may be cancelled only if the journey abroad does not take place as a result of death or illness of the Insured or his/her close family member. The insurance contract cannot be cancelled after the start of the insurance cover.
(3) In the event of the insurance contract cancellation, the Insurance Company shall return 85% of the paid premium.
(4) If the insurance duration is not specified in the contract or if it is specified with the possibility of extending the contract for the same period of time, each party may rescind the contract on the premium maturity date, provided that he/she has informed the other party about this a minimum of three (3) months before the maturity of the premium.
(5) If the insurance is taken out for more than three (3) years, each party may after the end of such period rescind the contract with a six-month notice period, provided that he/she has informed the other party about this in writing.

(6) In the event of a distance insurance contract (concluded online, via telephone, etc.), which has been concluded for a period longer than 30 days, the Policyholder may cancel the contract, however not later than 15 days before the insurance commencement. The cancellation must be made in writing and submitted to the Insurance Company by the end of the deadline, whereby it shall be considered that the cancellation has been filed in time if it was sent by registered mail by the end of the deadline. In this case, the Insurance Company shall be entitled to keep the premium (costs) for each day when it provided insurance cover. Under this paragraph, the Policyholder shall not have the right to cancel the contract in case of insurance contracts valid less than one month.

Article 13 EXPERT OPINION PROCEDURE

(1) Each contracting party may demand expert opinion on certain disputable matters.
(2) Each party shall appoint one expert from among the persons who are not in an employment or family relationship with the parties. Before the beginning of work, the appointed experts shall appoint a third expert to give opinion when the findings of the first two experts are different, and only within the limits of their findings.
(3) Each party shall bear the costs for the expert it has nominated. For the third expert, each party shall bear one half of the costs.
(4) Final conclusions are compulsory for both parties.

Article 14 CHANGES TO INSURANCE CONTRACT

(1) Should the Insurance Company change the insurance Terms and Conditions or the premium rating system, it must inform the Policyholder about the change in writing or in another appropriate way at least 60 days prior to the end of the current policy year.
(2) The Policyholder has the right to cancel the insurance contract within 60 days after having received the notice. The contract shall be terminated when the current policy year ends.
(3) Should the Policyholder not cancel the insurance contract, the contract will be changed in compliance with the new terms and conditions of insurance or the premium rating system as of the beginning of the following year.
(4) The Insurance Company reserves the right to correct any calculation or other mistakes made by the agent; the Policyholder must be informed in writing about any such correction. The Policyholder shall have the right to rescind the insurance contract within 15 days from the receipt of notice, provided that he/she does not agree with the corrections (changes to the insurance contract by the Insurance Company), whereby the rescission has a prospective effect. If the Policyholder does not rescind the insurance contract within this period of time, it shall be considered that he agrees with these corrections/changes, therefore the insurance contract shall apply from the end of this period onwards with the corrections (changes to the insurance contract by the Insurance Company).

Article 15 METHOD OF NOTIFICATION

(1) Agreements as regards the content of the Insurance contract shall be valid only if concluded in writing.
(2) Any notices and statements that must be provided under the provisions of the insurance contract must be made in writing.
(3) A notice or statement shall be deemed to be timely if it is sent by registered mail prior to the end of the deadline.
(4) A statement which must be made to the other party shall become effective only when the other party has received it.

Article 16 CHANGE OF ADDRESS AND SERVICE

(1) The Policyholder must inform the Insurance Company about a change of his/her address of residence or the seat or his/her name or company name within 15 days from the day of change.
(2) Should the Policyholder change his/her address of residence or his/her name or company name and should he/she fail to communicate it in writing to the Insurance Company, it shall be enough that the Insurance Company sends the notice, which it must communicate to the Policyholder, to the address of the Policyholder's last known address or seat, or to address it to the name or company name last known to it.
(3) If the attempt of servicing a registered notice to the Policyholder was unsuccessful (due to having moved, refusing to accept the notice, etc.), the Insurance Company shall consider the returned mail as being served and it will keep it at the seat of the Insurance Company. The Policyholder agrees that such notice is considered as having been received on the date of the first attempt of serving it and that it is considered that the Policyholder is familiar with the content of the notice.
(4) The assumption of successful servicing from the previous paragraph hereof has legally valid effects on the basis of the contractual agreement with the Policyholder.

Article 17 PROTECTION OF PERSONAL DATA

(1) Until recall, the Policyholder hereby allows the Insurance Company and the brokerage companies authorized by it to keep, process and use in their databases his/her personal data, which are needed for the implementation of insurance and for the purposes of informing the Policyholder and the Insured about news and offers related to financial products.

(2) The Insured hereby authorizes the Insurance Company and the Assistance Company to obtain and check on his/her behalf the medical documentation which is necessary to establish the circumstances for taking out the insurance and to establishing the Insurance Company's liability.

(3) The Policyholder hereby allows the Insurance Company to also provide personal data (name, permanent or temporary address, telephone number, e-mail address and telefax number) to other companies connected with the Insurance Company in terms of capital, i.e. all companies included in KD Holding and other affiliated or managing companies connected with the Insurance Company. These companies can use data only for direct marketing purposes including purposes of informing the Policyholder about news and offers related to financial products. The Policyholder also allows the Insurance Company to obtain necessary data from personal database administrators and provide them to the green card bureau or another body engaged in the settlement of the loss event.

(4) The Policyholder or the Insured may at any time demand the Insurance Company to stop using their personal data for direct marketing purposes from the previous paragraph. The Insurance Company hereby undertakes to prevent the use of personal data, for which permission was given according to the previous paragraph of this Article, not later than within 15 days.

(5) The Insurance Company hereby undertakes to keep all personal data with due diligence and care, pursuant to the applicable personal data protection law.

Article 18 SETTLEMENT OF DISPUTES

(1) The Policyholder, the Insured or the Beneficiary may within 15 days after having received a written decision from the Insurance Company file a written complaint to the Insurance Company, which must treat the complaint in accordance with its internal rules. The decision of the complaint committee shall be final and no further proceedings at the Insurance Company shall be possible.

(2) In case of disagreement with the decision made by the Insurance Company, proceedings for out-of-court settlement of dispute at a mediation center operating within the Slovenian Insurance Association may be continued if a special agreement is made. In certain cases this may be even brought before the Insurance Ombudsman.

(3) Slovenian law shall apply for relations concerning the insurance contract, which are not regulated herein.

(4) The Court in Koper shall be competent for deciding on any judicial disputes.

(5) The Insurance Supervision Agency, Trg republike 3, Ljubljana, is competent for the supervision over the Insurance Company.

CHART OF HEALTH INSURANCE COVER TYPES WITH ASSISTANCE ABROAD

INSURANCE COVERS				
Total for all insurance covers, a maximum up to the sum insured:		**€25,000** €20,000*	**€50,000** €40,000*	**€100,000** €60,000*
1.	**Urgent medical treatment costs, doctor's visit**	√	√	√
2.	**Costs of treatment**	√	√	√
3.	**Cost of transportation to the nearest hospital and back**	√	√	√
4.	**Transportation to the home country**	√	√	√
5.	**Medications and medical supplies**	√	√	√
6.	**Urgent dental services**	€100	€200	€300
7.	**Cost of transportation and accommodation for the person accompanying the Insured**	√	√	√
8.	**Accompanying a minor and transportation cost for a minor**	√	√	√
9.	**Cost of transportation for a family member**	Ticket	Ticket	Ticket
10.	**Cost of transporting the Insured's mortal remains to his/her home country**	√	√	√
11.	**Return in case of death of a family member**	√	√	√
	Age limit	75 years	75 years	75 years
	Age limit (additional premium required)*	85 years	85 years	85 years
	Age limit (additional premium required)**	above 85 years	above 85 years	above 85 years
	Geographic coverage	worldwide	worldwide	worldwide
	√ - included			

* Applicable for the insurance of persons who have permanent residence abroad but temporarily live and work in the Republic of Slovenia.