MetLife

VPPSNP 1.3
Effective from 1 April 2017
Code: Group 500

GENERAL INSURANCE CONDITIONS
GROUP NON-LIFE ASSURANCE

1 INTRODUCTORY PROVISIONS

1.1 These General Insurance Conditions are effective from 1 April 2017.

1.2 Specified accident and sickness insurance policies (including cases when such policies are taken out as supplementary insurance to life insurance policies) are governed by the insurance policy, these general insurance conditions VPP SNP 1.3 and relevant special insurance conditions. The general and special insurance conditions constitute an integral part of the insurance policy.

1.3 The insurance is governed by the laws of the Czech Republic and is subject to the relevant provisions of Act No. 89/2012 Coll., the Civil Code (hereinafter the **Civil Code**).

1.4 The provisions of the insurance policy shall take precedence over the provisions of the insurance conditions. The provisions of special insurance conditions shall take precedence over the general insurance conditions; the provisions of the general insurance conditions shall take precedence over the Civil Code.

How it works in practice
If the same situation is handled differently in special insurance conditions and general insurance conditions, then provisions of the special conditions shall apply as they take precedence over the general conditions.
Do you have a non-standard requirement that is not taken into consideration in the insurance conditions? Some situations can be easily addressed by making individual adjustments directly in the insurance policy.

1.5 Insurance is arranged as fixed amount insurance, unless expressly provided otherwise in the special insurance conditions.

2 TYPES OF INSURANCE, GROUP OF INSUREDS, INCLUSION TO INSURANCE

2.1 Supplementary insurance, with the exception of accidental death insurance, may be agreed in the insurance policy.

2.2 The insurance risk and insured event in respect of the relevant insurance are always specified in the special insurance conditions.

2.3 Some of non-life insurance may be taken out as supplementary insurance to ordinary life assurance. The insurance company has the right to determine which types of supplementary insurance or combinations thereof may be added to the insurance policy and what restrictions shall apply to them.

2.4 The group of persons entitled to be covered under the scheme is specified in the insurance policy. The insurance policy may contain several groups of persons entitled to cover. The persons are usually included in individual groups according to different criteria for participation or according to their salary or other remuneration.

2.5 Individual insureds are included in the insurance subject to the following conditions:

a) on the date of entry into the scheme the prospective insured actively works for the policyholder, whether on the basis of an employment contract or other contractual relationship;

b) the policyholder has notified the insurance company of the prospective insured in the report submitted to the insurance company on a regular monthly basis;

c) the prospective insured meets all criteria set out for the relevant group of insureds.

2.6 If multiple groups exist within the insurance scheme and if an insured member of a group meets conditions for participation in another group, the insurance company will make the change applying the following rules:

a) the policyholder will include the change in the regular report sent to the insurance company;

b) as of the date of the change the insured actively works for the policyholder;

c) the change will be made on the first day of the month following the month in which the change was reported.

2.7 If the insured does not meet the condition under point b) of the preceding paragraph, the provisions of Article 7.5 apply to the inclusion in a new group (and hence the beginning of the insurance provided for this group).

3 INSURABLE INTEREST

3.1 The insurance policy is concluded between the insurance company and the policyholder. The person to whose life or health the insurance relates is the insured. The person who as a result of an insured event will be entitled to benefits under this insurance is the person entitled. In the case of the life insured's death, the person entitled is the beneficiary.

Who is who
The insurance company is MetLife.
The policyholder is the person that concludes the insurance policy and pays the premium.
The insured is the person whose life is insured by the insurance policy.
The person entitled is the person entitled to the insurance benefit.
The beneficiary is the person entitled to the insurance benefit in the case of the insured´s death.

In practice, it is of course possible that one person may simultaneously perform several of the above roles.

3.2 If the insured person or the person entitled is other than the policyholder, the policyholder's insurable interest in such insurance must exist on concluding the insurance policy as well as during the term of the insurance. The insurable interest is demonstrated by the consent of the insured or expressed in the insurance policy.

3.3 If the Policyholder's insurable interest ceases to exist during the term of the insurance, the policyholder shall notify the insurance company of such fact. In this case, the relevant insurance shall also be considered expired; however, the insurance company will be entitled to insurance premiums payable until such time when it was informed of the insurable interest expiry.

4 INSURANCE OF OTHER PERSON´S INSURANCE RISK

4.1 If the policyholder is not at the same time the insured, the insurance is considered to be insurance of other person's insurance risk. Such coverage can be arranged for the benefit of the policyholder, the insured or other person entitled.

4.2 If the insurance of other person's insurance risk is taken out for the benefit of the policyholder or a person entitled other than the insured, the policyholder or such other person entitled may file a claim only if they can prove that:

a) the policyholder acquainted the insured with the contents of the insurance policy, and

b) the insured is aware that the insurance benefit will not be provided to him/her, but to the policyholder or other person entitled and he/she approves that the policyholder or other person entitled will receive the insurance benefit.

4.3 The policyholder or the person entitled shall prove the consent of the insured within the meaning of the preceding paragraph at the latest upon filing the claim. The consent of the insured will not be required if the policyholder is a legal representative of the insured. If the insurance benefit is claimed without the insured's consent, it will be the insured that will be entitled to receive the insurance benefit or, in the case of his/her death, a person designated pursuant to the terms of the Civil Code.

4.4 If insurance of other person's risk is taken out for the benefit of the insured, the insured may give his/her consent to the insurance only upon filing the claim.

What is important
Insurance of other person's risk is the situation when the policyholder is not at the same time the insured (e.g. the employer buys insurance for an employee or the bank for a client). The employer can file a claim under the insurance policy only with the consent of the insured (i.e. the employee).

5 DESIGNATION OF A PERSON ENTITLED AND A BENEFICIARY

5.1 If the insured event is the death of the insured, the policyholder may designate the beneficiary as the person entitled. The policyholder will do so in a written notification which will state either the beneficiary's name or his/her relation to the insured. The beneficiary is revocable at any time and the policyholder may change the beneficiary in writing until occurrence of the insured event. A change of the beneficiary will become effective upon the delivery of the change notification to the insurance company. If the policyholder is other than the insured, the policyholder may appoint or change the beneficiary or, in the case of several beneficiaries, determine or change their shares in the insurance benefit only with a written consent of the insured.

5.2 The policyholder authorizes each insured to designate or change the beneficiary in relation to his/her insurance policy.

5.3 Should there be no beneficiary appointed or should the beneficiary not acquire the right to the insurance benefit at the insured event time, the right will be acquired by persons who are entitled to the benefit in accordance with the applicable provisions of the Civil Code.

5.4 Provided that the relevant conditions have been met and the right to benefits has arisen, but the insured or the person entitled died before the payment of the benefit, the benefit will be dealt with as part of the estate, i.e. in inheritance proceedings.

5.5 If the insured event is an event other than the death of the insured, the insured is the person

entitled, unless agreed otherwise in the insurance policy.

In a nutshell
When the insured dies, the insurance benefit is paid to the beneficiary. The beneficiary is either named (e.g. "Jana Nováková") or his/her relation to the insured is stated (e.g. husband, children, parents, employer, bank, etc.). The beneficiary may be changed at any time during the term of the insurance. If the policyholder did not appoint a beneficiary, the beneficiary will be designated in accordance with the Civil Code.

6 CONCLUSION OF THE INSURANCE POLICY AND AMENDMENTS TO IT

6.1 An insurance policy is concluded on the basis of an insurance proposal, which is usually made by the insurance company to the person interested. If the insurance policy is to be concluded, it is necessary that the proposal is adopted without any amendments and variations within the period specified in the proposal. The insurance policy is considered concluded on the day of its signing by the other contracting party.

6.2 The method of amending the insurance policy is agreed in the insurance policy.

6.3 The provisions of the new Civil Code relating to the protection of the weaker party in respect of adhesion contracts shall not apply in relation to the policyholder.

How it works in practice
Adhesion contract is a standardized form contract drafted by one party and signed by the other party. It contains standardized terms, does not allow for negotiation and is filled out only in optional parts.

7 BEGINNING OF INSURANCE, TERM OF INSURANCE AND INSURANCE PERIOD

7.1 The insurance is concluded for a fixed term and ends with the expiry of the insurance period.

7.2 If the insurance policy is concluded for a term longer than 1 (one) year, the period of insurance is 1 (one) year.

7.3 The insurance could be concluded for the term of 1 (one) year with automatic renewal. If neither of the contracting parties notifies the other contracting party at least 6 (six) weeks before the expiry of the term of insurance of its intention not to renew, the insurance policy shall be renewed on the same terms by another year.

7.4 Unless otherwise provided in the insurance policy, the policy is concluded for a fixed term of 1 (one) year. The policy may always be extended by another year on the same conditions. The proposal to amend the insurance policy in connection with extension of the term is made by the insurance company and the policyholder accepts it by timely payment of the premium or premium instalment specified in the proposal.

7.5. The inception date of insurance cover in relation to individual insureds is determined as follows:

a) the date on which the last condition for entry of the prospective insured into the group was met; however, only if the insured was reported to the insurance company before that date, or on that date;

b) the date on which the last of the conditions for inclusion in the group has been met, and for insurance cover including sickness insurance, the insured must be reported to the insurance company no later than 31 days after the last of the conditions;

c) for insurance coverage included sickness the date on which the insurance company decided to include the prospective insured in the insurance scheme, provided that the prospective insured met the conditions, but was reported to the insurance company after the expiry of 31 days from meeting the conditions, or if he/she applies for entry in the scheme and has already been working for the policyholder for some time without participation in the insurance. In this case, the person is required to submit to the insurance company relevant documents proving his/her insurability.

In a nutshell
Point a) applies to insureds included in the insurance as of the effective date of the group insurance policy. Point b) applies to new staff and point c) to the persons who, for whatever reason, have asked for entry in the insurance scheme only after a certain period of time since when they met the inclusion criteria. In this case, the insurance company usually examines the state of health of the person; this does not apply to insurance cover related to the accident of the insured.

8 INSURANCE PREMIUM

8.1 The insurance premium is arranged either for the entire term of insurance (single premium) or for individual insurance periods (regular premium). The insurance policy always sets out whether the insurance is arranged as single premium or regular premium, how much it is or how its amount is calculated. Payment of a regular premium in instalments may be arranged in the insurance policy. The premium or premium instalment is mathematically rounded to whole crowns.

8.2 If the premium amount is determined with regard to the age of the insured, and unless provided otherwise in the insurance policy, the insured's entry age in years is calculated as the difference between the inception year of the insurance and the year of birth of the insured. However, if the inception day in the calendar year is earlier than the day of birth of the insured in the calendar year, the age at entry calculated pursuant to the preceding sentence will be reduced by one year.

8.3 The premium due date is stipulated in the insurance policy. If the party interested paid an advance premium in connection with the insurance proposal, upon conclusion of the insurance policy the insurance company shall consider such advance payment as the premium.

8.4 The insurance company is entitled to premiums for the duration of the insurance. If an insured event results in the insurance termination, the insurance company will be entitled to the premium for the whole insurance period in which the insured event occurred; if the policy is a single premium policy, the insurance company will be entitled to the premium for the entire term for which the insurance was taken out.

8.5 The policyholder shall pay the premium in the amount, currency, at the date and into the account specified in the insurance policy and shall use the payment identification details (especially the variable symbol) prescribed by the insurance company. If the premium calculation and payment depend on the policyholder's reporting duty towards the insurance company, the policyholder shall pay the premium on the basis of the premium advice received.

8.6 The insurance company has the right to deduct from the insurance benefit any receivable premiums and/or other receivables arisen out of the insurance.

8.7 Before the expiry of the term of the insurance, the insurance company will redetermine the premium amount with respect to the new composition of the group of insured persons (age, sex, number of insureds, sums assured) and 2 (two) months prior to the expiry of the policy term will send the policyholder a proposal for a premium adjustment for the next policy term.

If the policyholder does not accept the proposal or does not submit any other proposal for the premium adjustment and if the insurance policy is extended automatically, cover will be extended on the same conditions.

9 TERMINATION OF INSURANCE

9.1 The insurance of an individual insured member shall cease to exist in the following circumstances:

a) by agreement between the insurance company and the policyholder;

b) upon the expiry of the policy term; it may be agreed in the insurance policy that the insurance will not end by expiry of the policy term unless the insurance company or the policyholder notifies the other party at least 6 (six) weeks before the expiry of the term of the insurance of its intention not to renew the insurance policy;

c) by 8 (eight) days' notice of cancellation given within 2 (two) months from concluding the insurance policy; however, the insurance company will be entitled to the premium until the insurance cover end;

d) by notice of cancellation given by the policyholder at the end of the insurance period, provided that the notice is given at least six (6) weeks before the end of such period; if the notice is delivered later, the insurance will only be terminated at the end of the insurance period for which this 6-week period was observed;

e) upon the lapse of the time limit set out in the past-due premium payment reminder issued by the insurance company; such time limit must be at least 1 (one) month from the delivery of the reminder and the reminder must specify consequences of the failure to pay;

f) by the policyholder withdrawing from the insurance policy, without giving any reason, within 14 (fourteen) days of concluding the insurance policy; this provision applies only if if the insurance policy was concluded outside the business premises of the insurance company; withdrawal from the insurance policy is also possible on the grounds of breach of obligations, particularly in cases referred to in Article 10 below;

g) by 1 (one) month´s notice of cancellation given by the policyholder within 3 (three) months from the date of an insurance event notification;

h) if the insurable interest ceased to exist; however, the insurance company will be entitled to the premium payable until such time when it was informed of the insurable interest expiry;;

i) when the insurance risk ceased to exist or upon the death of the insured.

Cancellation of cover in respect of an insured person will not result in duration of other insured persons' cover and neither will it bring about cancellation or termination of this group insurance policy.

9.2. Insurance cover of individual insureds will end for the following reasons:

a) at 24:00 hrs on the day on which the employment relationship or other contractual relationship between the insured and the policyholder, on the basis of which the insured was entitled to participate in the insurance, is terminated;

b) at 24:00 hrs on the day when the insured ceased to meet any of the conditions for participation in any of the groups set out in the insurance policy;

c) at 24:00 hrs on the day when the group insurance policy is terminated;

d) at 24:00 hrs on the day on which the insured's incapacity to work exceeded the period of 12 (twelve) continuous months.

e) at 24:00 hrs on the day when supplementary insurance of permanent total disablement ceases to exist.

9.3. In case of termination of Term Life insurance any supplementary insurance arranged in the insurance policy is terminated.

10 INSURANCE OBLIGATIONS AND CONSEQUENCES OF THEIR BREACH

10.1 Obligations in relation to the insurance risk

The insured shall take care not to increase the insurance risk. However, if the insurance risk increases, he/she shall notify the insurance company of the risk increase without undue delay.

A change in the insurance risk occurs if facts about which the insurance company inquired when underwriting the insurance or which are indicated in the insurance policy (change of job, risk group or other circumstances) have changed so much that they increase the probability of occurrence of an insured event.

If the insurance risk has increased, the insurance company will have the right to:

a) propose a different premium amount, provided it can prove that it would have underwritten the risk on different terms if the increased risk had existed on negotiating the policy; if the policyholder does not accept the proposal, the insurance company may terminate the insurance by 8 (eight) calendar days' notice of cancellation;

b) terminate the insurance by 8 (eight) calendar days' notice of cancellation, if it can prove that it would never underwrite such policy if the insurance risk was so high;

c) terminate the insurance without notice, if the insured breached his/her obligation to notify the insurance company of an increase in the insurance risk; in such a case the insurance company will be entitled to the premium until the end of the insurance period in which the cover was cancelled or to the full single premium;

d) reduce the insurance benefit, if the policyholder failed to observe the obligation to inform the insurance company of an increase in the insurance risk and if an insured event occurred after such change in the risk; the benefit will be reduced in proportion of the premium received to the premium that should have been paid, had the insurance company been notified of the increased insurance risk in time.

What is important
If the circumstances of the insured person change in a way that could influence cover (e.g. a teacher becomes a truck driver), the insurance company should be informed about the change immediately in order to assess whether the insurance risk has changed or not.

10.2 **Giving the correct date of birth**

The policyholder is obliged to state the correct date of birth of the insured in the insurance policy. This is valid only for insurance cover including sickness insurance.

If, as a result of being given an incorrect date of birth, the insurance company determines a smaller premium or sum assured, shorter policy term and premium payment period, it will be entitled to reduce the insurance benefit in proportion of the premium that has been paid to the premium that would have been paid if the policyholder had given the date of birth of the insured correctly.

If the insurance company becomes aware of the deliberate breach of the policyholder's obligation after it had provided the insurance benefit, the recipient of the benefit will be obliged to pay back a proportion of the benefit which corresponds to the benefit reduction. Fulfilling this obligation is the responsibility of the Policyholder.

If the date of birth of the insured was stated incorrectly, subject to the terms laid down in the Civil Code, the insurance company has the right to withdraw from the insurance contract. The insurance company may only enforce the right during the lifetime of the insured and within 3 (three) years from the date of conclusion of the insurance policy, but not later than 2 (two) months after it became aware of the incorrect information.

10.3 **Truthful representations before concluding the insurance policy and when changing it**

When arranging the insurance, the policyholder and the insured are obliged to answer truthfully any written questions of the insurance company which are relevant for the insurance company's decision on how to assess the risk, whether to underwrite it or not and on what conditions, and not to conceal any material facts. The same obligation applies if changes are made in the insurance policy.

When arranging the insurance, the insurance company is obliged to answer truthfully and completely the policyholder's written questions regarding the insurance. The insurance company is also obliged to draw the policyholder's attention to any discrepancies which exist between the cover offered and the prospective client's requirements and of which it is or should be aware.

Should the policyholder, the insured or the insurance company breach the above obligation, the other party, subject to terms laid down in the Civil Code, will have the right to withdraw from the entire insurance contract or void the relevant part thereof.

If the policyholder withdraws from the insurance contract, the insurance company shall refund the already received premium less any benefit, if provided, within 1 (one) month from the date on which the withdrawal became effective. If the insurance company withdraws from the insurance contract and if the policyholder, the insured or other person has already received a benefit, within the same time limit he/she will reimburse to the insurance company the excess of the received benefit over the premium paid. In such a case the insurance company has the right to offset its costs associated with the issuing and administration of the insurance.

10.4 **Truthful representations in connection with an insured event**

The insurance company may repudiate a claim under the insurance policy if:

a) the cause of the insurance event was a circumstance of which the insurance company became aware after the occurrence of the insurance event and which it could not find out on arranging the insurance because of untrue or incomplete answers given to written questions intentionally or out of negligence and if – on condition that the insurance company had known about the circumstance at the time of concluding the policy –

it would not have concluded such insurance policy or would have concluded it on different terms, or

b) when filing a claim, the person entitled deliberately provided untrue or grossly distorted material data relating to the scope of the insurance event or has concealed material data relating to the occurrence.

The insurance is terminated as of the date of the policyholder receiving a notice that the claim was repudiated. No premium is refunded in this case.

In the case referred to in point b) above, the insurance company will be entitled to compensation of expenses reasonably incurred in investigation of circumstances of which it was deliberately given untrue or grossly distorted material data or the material data of which were concealed to it. It is understood that the insurance company incurred expenses in the proven amount reasonably.

In a nutshell
Obligations of the policyholder/insured/person entitled:
- **answer all questions truthfully when arranging insurance,**
- **indicate the correct date of birth of all persons,**
- **immediately notify the insurance company of an increase in the risk (e.g. change of job)**
- **provide truthful information about the insured event.**

Obligations of the insurance company:
- **answer the policyholder's written questions regarding the cover truthfully and completely,**
- **draw the policyholder's attention to potential discrepancies between the insurance offered and the policyholder's requirements.**

10.5 **Alcohol, addictive drugs and crime**

The insured is obliged to act so as to prevent occurrence of the insured event.

The insurance company may reduce the insurance benefit by up to a half if an injury was sustained due to the fact that the injured person had consumed alcohol or ingested an addictive drug or a product containing such drug, provided that such reduction is justified in view of the circumstances in which the injury was sustained. However, if the injury resulted in the death of the injured person, the insurance company will be entitled to reduce insurance benefits only on condition that the injury was sustained in connection with an act of the injured person by which he/she caused damage to health or the death of another party.

The insurance company shall not enforce the right under the preceding paragraph if alcohol or an addictive drug were part of a medicine prescribed to the injured person by the doctor and if the injured person was not warned by the doctor or the medicine manufacturer that during the action of the medicine he/she should not carry out the activity which led to the injury.

The insurance company has also the right to repudiate a claim if the insured sustained an injury in connection with an act for which he/she was found guilty of a premeditated crime or by which he/she deliberately harmed his/her health.

11 PROCEDURES AND OBLIGATIONS IN CASE OF AN INSURED EVENT / INSURANCE BENEFITS

11.1 The person entitled shall notify the insurance company on the appropriate form without undue

delay that an insured event has occurred, and shall give a true explanation of the rise and scope of consequences of the event and submit necessary documents. If the insured event is the death of the insured, this obligation shall be performed by the beneficiary.

11.2 Unless otherwise expressly provided in special insurance conditions, costs associated with filing a claim or investigating the insured event are borne by the party that incurred them.

11.3 If the policyholder, the insured or the person entitled submit to the insurance company documents in a language other than Czech or English, upon the insurance company's request they shall arrange for their certified translation at their own expense.

11.4 If the policyholder, the insured or other person enforcing the right to benefits brings about investigation costs or their increase by breaching an obligation, the insurance company will be entitled to adequate refund of the reasonably incurred additional costs. It is understood that the insurance company incurred the costs in a proven amount reasonably.

11.5 Following a due notification of an insured event, the insurance company shall start investigation without undue delay to determine the extent of its obligation to provide benefits. The investigation is considered complete on the date when the insurance company informs of its results the person entitled. The insurance company is obliged to complete the investigation within 3 (three) months from the date when it was duly notified of the insured event. If the insurance company is unable to complete the investigation within that period, it shall inform the person who is or will be entitled to the benefits of the reasons why the investigation cannot be completed, and upon such person's request shall pay him/her a reasonable advance. The above limit will not apply if the investigation is made impossible or hindered by the fault of the person entitled, the policyholder or the insured.

11.6 The insurance benefit is payable within 15 (fifteen) days from the completion of the investigation. The benefit is mathematically rounded to whole crowns and is payable in the Czech Republic in the currency of the Czech Republic.

11.7 The claim limitation period is 3 (three) years and will start to run 1 (one) year after the insured event.

Summary

1. **You should notify a claim without undue delay (fill in and post the appropriate form).**
2. **You should provide true explanation of the rise and scope of consequences of the event and support it with necessary documents (e.g. photographs, statements by witnesses, medical reports, etc.).**
3. **The insurance company will start investigation without undue delay to establish the extent of the benefit. The investigation must be completed within three months from the claim notification date.**
4. **The benefit is payable within 15 days from the end of investigation.**
5. **Please note: The limitation period of 4 years starts to run from the insured event date. If you do not notify a claim within the above time limit, your claim will be forfeited and the insurance company will not pay you the benefit.**

12 COMMON EXCLUSIONS

12.1 No right to benefits under the relevant insurance will arise if the insured event occurs as a result of:

a) deliberate physical harming or attempting to do so regardless of the mental state of the Insured,

b) intoxication or the influence of narcotics, except where narcotics were administered upon the recommendation of the doctor and if no overdose happened,
c) deliberate participation in illegal activity, violation or attempted violation of the law, resisting arrest,
d) death of the insured or other insurance event of the Insured caused directly or indirectly by his/her active participation in a war. War is defined as declared or undeclared war, invasion, action of foreign powers, conflicts, unrest, riots, civil commotion, civil war, rebellion, revolution, insurrection, conspiracy, military forces, state of emergency, state of siege or other events that led to the imposition and maintenance of martial law or state of siege,
e) service in the armed forces of any country or international authority in times of peace and war (eg. a member of the police rapid reaction force, rapid response unit or a similar department or unit, professional soldier or officer or member of military crews of vessels and aircraft),
f) in relation to radioactive or ionizing radiation resulting from a nuclear disaster, failure of a nuclear installation or use of a weapon;
g) flight of the insured as a pilot or crew in a private, military or any other aircraft,
h) flight of the insured as a passenger in any kind of aircraft, except in cases where the insured travels as a passenger on a scheduled air flight,
i) insured participation in sports and entertainment activities associated with high risk, including participation in national and international competitions,
j) participation in any professional sport activities (races, competitions, including the preparation and training),
k) work with explosives or as a stuntman, acrobat or in a similar job

Examples from practice
High-risk activities include, in particular, aviation sports of all kinds (e.g., skydiving, parachuting, paragliding and flying, including hang-gliding and hot air ballooning), bungee jumping, mounting climbing, roping, canyoning, canoeing, rafting and other white water rafting from Class 3 and higher, diving, spelunking, acrobatics, ski jumping, skiing and snowboarding outside marked slopes and trails, ski mountaineering, BMX freestyle and racing, martial arts and contact sports, motor sports of all kinds, riding on motor vehicles off main roads, motorways and local roads, and other similar extreme sports. It is not possible to list all activities; however, if you would like to verify whether the activity you wish to carry out is a high-risk activity please do not hesitate to contact us.

13 FORM OF LEGAL ACTS AND NOTIFICATIONS

13.1 Legal acts aimed at amending or terminating an insurance policy shall be made in writing.

13.2 Notifications concerning claim payments, changes of the person entitled or the beneficiary, changes in the shares of individual beneficiaries in benefits in the case of several beneficiaries and other similar notifications shall be always made in writing. The insurance company has the right to request that the signature of the person who makes such notification be officially authenticated or verified by an authorized representative of the insurance company.

13.3 A legal act or notification under paragraph 15.2 is considered valid if the acting person's own signature is attached to the text or if the text is provided with a guaranteed and certified electronic signature or if the document is delivered via a data box.

13.4 Notifications concerning other facts related to the insurance policy or cover do not require a written form and may be made by appropriate electronic or other technical means, especially by phone or e-mail. Notifications sent by e-mail are acceptable only if sent from the e-mail

address specified in the insurance policy or from an email address that the policyholder provided to the insurance company in writing. Notifications made from any other e-mail address will not be considered received. If the insurance company asks for additional written information on the basis of e-mail communication, the policyholder shall do so within 5 (five) working days.

What is important
Important changes of the insurance policy (adjustment, termination, claim notification, payment of benefit, change of beneficiary, etc.) must be always made in writing.

14 DELIVERY OF MAIL

14.1 The contracting parties shall deliver their notifications and other documents under the insurance policy to the address specified in the insurance policy. The insurance company and the policyholder are obliged to inform the other party of a change of their address without undue delay. Notifications are then delivered to the new address. The delivery address must be located in the Czech Republic.

14.2 Unless the delivery is carried out in accordance with subsequent paragraphs, a document sent by the insurance company as registered mail with a return receipt shall be deemed delivered on the day specified as the date of receipt on the return receipt; a document sent by the insurance company by registered mail without a return receipt shall be deemed delivered on the third workday after posting, and if sent to an address in a country other than the Czech Republic, then the fifteenth workday after sending.

14.3 If the document sent by the insurer as registered mail or as registered mail with a return receipt is deposited at the post office and the addressee does not collect it within the period set out for depositing registered mail, the mail shall be deemed delivered by the expiry of such period even if the addressee did not know about the mail or did not abide at the delivery address.

14.4 If the policyholder does not notify the insurance company of his/her delivery address change as stated above, or refuses to accept the mail or otherwise frustrates its delivery, the mail shall be deemed delivered the third workday after posting.

What is important
Communication and correspondence addresses are specified in the insurance policy and the other party should be informed of any change of them without undue delay.

15 ESTABLISHING AND REVIEWING THE STATE OF HEALTH OF THE INSURED

15.1 The insurance company has the right to require information about the insured's health and request the establishing of his/her state of health or the cause of his/her death, if reasons for such request relate to the assessment of the insurance risk, rating and investigation of the insured event, provided that the insured gave the insurance company his/her consent to it.

15.2 The state of health or cause of death are established on the basis of medical reports and records which the health facility authorised by the insurance company will receive upon request from the insured's health care providers; if necessary, additional medical examination or tests are carried out by a health facility designated by the insurance company.

15.3 In the event of an accident resulting in death of the insured, the insurance company reserves the right to inspect the insured's body and, if needed and not prohibited by law, to have

an autopsy carried out at its own expense.

16 ALTERNATIVE DISPUTE RESOLUTION

Authority for alternative dispute resolution in non-life insurance is the Czech Trade Inspection: www.coi.cz

17 DEFINITIONS

For the purposes of accident insurance, sickness insurance or supplementary insurance under these conditions the following terms have the meanings attributed below:

17.1 **Doctor** – a person with academic qualifications in medicine (medical school graduate) who in the extent of his/her medical attestation or licence treats the insured for an injury or illness which resulted in an event that may give rise to a claim under the insurance policy or supplementary insurance. Doctor must not be the policyholder and/or any of the insureds and/or family members.

17.2 **Disease** – a change in the bodily health of the insured with which he/she was first taken ill after the date of joining this insurance and after the expiry of the relevant waiting period.

17.3 **Civil War** – an armed conflict between two or more parties in the same country, where opposing parties belong to different ethnic, religious or ideological groups. The definition includes: armed rebellion, revolution, uprising, riots, coups, the consequences of martial law.

17.4 **Professional sportsman** or **professional sports activities** – a person who, in connection with her/his sporting activities receives wage-earning revenue (on the basis of employment) or other income (e.g. as a self-employed person, OSVČ).

17.5 **Accident** – an unexpected and sudden impact of an external force or the insured's own body force independently of the insured's will, which occurred during the policy term and which caused the insured's injury or death.

17.6 **War** – a declared or undeclared armed conflict between two states.

17.7 **Policy anniversary** – the first day of the second and next policy periods.

What is important

Terms used in insurance need precise definitions, which is why we provide them. Explanations of other terms can also be found in special insurance conditions.

[VPPSNP1.3]