GENERAL INSURANCE TERMS AND CONDITIONS
FOR BODILY INJURY AND SICKNESS

1. INITIAL TERMS
The relationship between the insurer, the policyholder and the insured in relation to the bodily injury and sickness insurance is governed by (1) the policy; (2) the contractual amendments to the policy; and (3) these conditions. The above documents (2) and (3) are indivisible parts of the policy. The policy or these conditions may also refer to a questionnaire answered by the policyholder and the insured(s) or to a risk report submitted by an insurance broker.

2. DEFINITIONS
Unless otherwise stated, the following expressions written in italic have the following meanings:
Accumulated limit of insurance payment means amount set out in the policy as the maximum amount of the insurance payment in case of insured events arising out of the same cause to more insureds;
Aircraft means any equipment intended for a movement in the air, without regard to the fact if it is manned or unmanned, with or without an engine, heavier or lighter than the air and without regard to the fact if it has been approved or registered;
Beneficiary means a person who shall become entitled to insurance payment in case of death of the insured;
Bodily injury means bodily injury caused by unexpected, sudden and accidental external circumstances which occurred independently of the will of the insured while the insurance is in the force; the external circumstances pursuant to the previous sentence also include drowning, strike by lighting or electric current, effect of low or high temperatures, effect of gas, steam or toxic substances, provided that the aforementioned comply with the conditions and other provisions of the policy. The insurance excludes bodily damages caused by any earlier bodily injuries or sicknesses, and any sicknesses, including where a pre-existing sickness appears or is aggravated as a consequence of the injury, any fits, mental disability or alteration of the psychological state irrespective of their cause.
Burns means damage to the integrity of the skin caused by contact with a heat energy source, chemicals or a source of very low temperature, irrespective of whether permanent consequences are caused;
Conditions means these general insurance terms and conditions [type];
Deductible means amount set out in the policy, by which the insurance payment for particular consequences of the insured event shall be reduced, or the period of time set out in the policy expressed in days or hours for which there is no right to insurance payment; for the purpose of assessment whether the limit of insurance payment has been achieved the deductible is added to the insurance payment to be provided;
Fracture means traumatic damage to the integrity of bone due to injury, regardless of the fact whether it causes any permanent consequences or not;
Franchise means amount or a period specified in the policy, up to which or till whose expiry the insurer shall not provide the insurance payment in case of insured event. If the amount or the period is exceeded the insurer shall provide the insurance payment in full; unless agreed otherwise in the policy, the franchise shall apply to each consequence of the insured event, which is covered by this insurance;
Hazardous sport means flying with gliders, sail planes with a stand-by motor, ultra light and sports planes, flying with air-balloon, hang gliding, paragliding, parasailing, skydiving and parachute flying and all other air sports; further rock-climbing, speleology, bungee-jumping, as well as other similar sports and all other sports stated in the policy;
Hospital means medical establishment licensed as a medical practice and operating for the admission and treatment of mainly in-patients who receive treatment for illness or injury; the establishment must have facilities for surgical and diagnostic treatment of patients, 24-hour care provided by qualified medical nurses and at least one consultant. An establishment that is a day clinic, treatment centre, rehabilitation clinic, convalescent home, geriatric care centre, a place for the treatment of the chronically-ill, addicts, those with psychiatric disorders, a recuperative centre,
Hospitalisation means admission of the **insured** to the **hospital** ward for a period of at least 24 hours receive a treatment;

**Insured event** means accidental event which meets the attributes specified in these **conditions**, with which triggers the obligation of the **insurer** to provide an insurance payment;

**Insured peril** means possible cause of occurrence of an **insured event**;

**Insured** means person namely specified in the **policy** or defined by a relationship to the **policyholder** or a certain group of people, whose life and health is covered by this insurance; unless agreed otherwise in the **policy**, the insurance covers only persons under 65 years of age and the person ceases to be an **insured** by reaching this age;

**Insured risk** means a rate of probability of occurrence of an **insured event** caused by an **insured peril**;

**Insurer** means AIG Europe Limited, se sídlem The AIG Building, 58 Fenchurch Street, Londýn, EC3M 4AB, Spojené království Velké Británie a Severního Irska, zapsaná v Rejstříku společností pod číslem 01486260, jednající prostřednictvím AIG Europe Limited, organizační složka pro Českou republiku, se sídlem V Celnici 4/1031, 110 00 Praha 1, identifikační číslo 242 32 777, zapsaná v obchodním rejstříku vedeném Městským soudem v Praze, oddíl A, vložka 75864

**Limit of insurance payment** means amount set out in the **policy** as the maximum amount of the insurance payment;

**Loss event** means an event leading to damage, loss or destruction which could constitute a right for insurance payment;

**Loss** means in relation to a limb or an organ its physical loss or permanent loss of its function; the loss of an eye is deemed to be a total and incurable loss of sight expressed as a state when after convalescence the degree of eye-sight does not exceed 3/60 on the Snell scale; loss of hearing or speech means the total and incurable loss of hearing or speech;

**Pathological fracture** means fracture occurring at a point weakened by a previous sickness;

**Period of insurance** means the time period agreed in the **policy** for which premium is paid; unless agreed otherwise in the **policy**, the period of insurance lasts 12 month;

**Policy** means agreement concluded between the **insurer** and the **policyholder** under these conditions;

**Policy period** means period of time set out in the **policy**, for which the insurance has been concluded;

**Policyholder** means a person who concluded the policy with the **insurer** and is obliged to pay the premium; the **policyholder** can be an **insured** at the same time;

**Radioactive pollution** means ionising radiation or radioactive radiation coming from nuclear fuel or nuclear waste originating from burning of nuclear fuel and further impacts of radioactive, poisonous or in other way dangerous properties of any nuclear device or nuclear part of any device;

**Sickness** means any fortuitous deterioration of the **insured's** physical condition during the **policy period**, but excluding any sickness or illness which arises out of or is caused by a condition or defect for which medical treatment was recognised, advised, sought out, or should have been reasonably sought out, or received at any time before the **policy period** or before the expiry of the waiting period. The sickness shall mean only such deterioration of the **insured's** physical condition for which medical treatment was sought out before the end of the **policy period**;

**Statutory rules** means act no. 40/1964 Coll., Civil Code, act no. 37 /2004 Coll., on Insurance Contracts and other statutory rules pertaining to insurance;

**Sum insured** means an amount set out in the **policy** as a ceiling of the insurance payment;

**Terrorism** means actual or threatening use of force or violence directed against any person, property or government, as well as committing an act disturbing or hampering activity of electronic or communication devices done by an individual or a group of persons without regard to the fact whether they act independently or on behalf or in connection with any organisation, government, power, authority or armed force, with the aim to threaten or harm government, civil population or its part, force them to any kind of action or disturb any sector of economy. Terrorism is also any act which was as such recognised or declared by any relevant government;

**Total and permanent disablement** means a condition as a result of an **injury** or **sickness**, which completely and permanently inhibits the **insured** from carrying out any work or doing any other
gainful activity, lasting at least one year and with all probability for ever, for avoidance of doubt the term disability in the sense of these conditions is not identical with a similar term used in the legislation regulating social security;

Valuation tables (tables of benefits) means tables which are the basis for establishment of the insurance payment for particular consequences of an insured event; the valuation tables are annex and inherent part of the policy;

Violent circumstances means riot, revolution, insurrection and disturbances which has a character of rebellion or military usurpation of a power;

War circumstances means war whether declared or not, hostile or warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other aims;

Work inability means a state when the insured is due to an injury or sickness temporarily unable on the grounds of a medical decision to carry out his/her work, independent business or other business and in confirmation thereof, a certificate of work inability has been issued to the insured in accordance with applicable provisions of law, provided that the insured has no medical insurance and no certificate of unfitness for work has been issued to him/her, evidence of his/her entitlement to the insurance benefit will be made by a written confirmation issued by the relevant doctor, such confirmation replacing the certificate of unfitness for work. A certificate of unfitness for work or confirmation replacing such certificate issued by a family member of the insured or a person close to the insured does not evidence the claim for insurance payment;

3. INSURED PERIL, INSURED EVENT
3.1 The insurer shall provide the insured with the insurance payment within the scope agreed in the policy provided that the insured event defined in these conditions occurs.
3.2 Insured event means, for the purposes of these conditions, following incidental events:
   a) bodily injury sustained by the insured within the period of insurance;
   b) sickness of the insured which occurs and as a result of which, the insured seeks medical treatment within the period of insurance on condition that such sickness did not occur before the inception of the period of insurance or the insured did not seek medical treatment in relation to such sickness before the inception of the period of insurance.
   according to what type of the insurance is agreed in the policy.
3.3 An event caused wilfully by the insured, policyholder, beneficiary or any other person acting on the initiative of one of them shall not be considered an insured event.
3.4 The exact scope of the insurance payment is agreed on in the policy. The insurance can be written in particular for the following consequences of bodily injury or sickness:
   a) death;
   b) total and permanent disablement;
   c) serious permanent dismemberment;
   d) permanent dismemberment;
   e) hospitalisation;
   f) fractures;
   g) burns;
   h) surgery;
   i) work inability;
   j) funeral expenses;
   k) other consequences of an insured event stated in the policy.
3.5 If the insurance of a specific consequence stated in section 3.4 is not agreed in the policy, the insurance shall not cover it. Insurance of other insured events can be, however, agreed in the policy.

4. SCOPE OF THE INSURANCE
The policy specifies the exact scope of the insurance payment which the insurer will make. Such scope may include:

4.1 Accidental death
4.1.1 If the policy stipulates the insurance in the event of the death of the insured as a result of a bodily injury and if within the period of insurance the insured sustains a bodily injury as a direct result of
which, independently of any other circumstances the insured dies within one year from the date of the bodily injury the insurer shall make the beneficiary the insurance payment in the amount of the sum insured.

4.1.2 The accidental death insurance payment for persons under the age of 18 is limited to a maximum amount of 50,000,- CZK unless otherwise agreed on in the policy.

4.2 Total permanent disablement due to bodily injury

4.2.1 If the policy stipulates the insurance in the event of total and permanent disablement as a result of bodily injury and if within the period of insurance the insured sustains bodily injury as a direct result of which, independently of any other circumstances, the insured suffers total and permanent disablement within one year from the date of the bodily injury, the insurer shall make the insurance payment to the insured up to the amount of the sum insured provided that the disablement of the insured lasted at least one year without interruption and shall in all probability become total and permanent at the end of that period.

4.2.2 The insurance of the total and permanent disablement does not cover persons under the age of 18.

4.3 Serious permanent dismemberment due to bodily injury

4.3.1 If the policy stipulates the insurance in the event of serious permanent dismemberment as a result of bodily injury and if within the period of insurance the insured sustains bodily injury as a direct result of which, independent of any other circumstances, the insured sustains serious permanent dismemberment within one year from the date of bodily injury, the insurer shall pay to the insured an amount equal to the multiple of the rate corresponding to the scope of loss specified in the table of benefits and the sum insured. No insurance payment shall be made until a medical certificate confirming serious permanent dismemberment is issued and the consequences of the bodily injury have stabilised.

4.3.2 The insurance payment shall be calculated on the basis of the table of benefits and is dependent on the extent of bodily damage to the insured, regardless of his/her ability to work.

4.3.3 There is no claim to insurance payment in the event of loss not specified in the table of benefits.

4.3.4 If the table of benefits specifies different percentage rates for left and right limbs, and the insured is proven to be left-handed, the specified percentage rates shall apply vice versa.

4.3.5 The total amount of the insurance payment, which shall be made for more than one loss sustained due to a single bodily injury, corresponds to the sum of amounts designated for each loss, but shall not exceed the sum insured.

4.4 Permanent dismemberment due to bodily injury

4.4.1 If the policy stipulates the insurance payment in the event of permanent dismemberment as a result of bodily injury and if within the period of insurance the insured sustains bodily injury as a direct result of which, independently of any other circumstances, the insured sustains permanent dismemberment within one year from the date of bodily injury, the insurer shall pay to the insured an amount equal to the multiple of the rate corresponding to the scope of loss specified in the table of benefits for permanent dismemberment and the sum insured. No insurance payment shall be made until a medical certificate confirming permanent dismemberment is issued and the consequences of the bodily injury have stabilised.

4.4.2 The insurance payment shall be calculated on the basis of the table of benefits and is dependent on the extent of bodily damage to the insured, regardless of his/her ability to work.

4.4.3 Insurance payment in the event of loss not specified in the table of benefits shall be determined by the insurer with reference to the type of the loss and its gravity compared to the closest related loss defined in the table of benefits.

4.4.4 If the table of benefits specifies different percentage rates for left and right limbs, and the insured is proven to be left-handed, the specified percentage rates shall apply vice versa.

4.4.5 The total amount of the insurance payment, which shall be made for more than one loss sustained due to a single bodily injury, corresponds to the sum of amounts designated for each loss, but shall not exceed the sum insured.

4.4.6 If the policy specifies the insurance of permanent dismemberment as with progressive payment, the amount of the insurance payment shall be calculated depending on the extent of the loss according to the table of progressive payment, which is attached to the policy, up to a maximum of four times the sum insured, unless otherwise specified in the policy.

4.5 Daily benefit in the event of hospitalisation
4.5.1 Hospitalisation due to bodily injury
If the policy stipulates the insurance in the event of hospitalisation in the form of daily benefit as a result of bodily injury and if the insured sustains bodily injury within the period of insurance as a direct result of which, independently of any other circumstances, the insured is within 30 days from the date of the bodily injury hospitalised for a period longer than the franchise stated in the policy, the insurer shall make the insurance payment specified in the policy to the insured for each day of hospitalisation but for no longer than for the period specified in the policy as the maximum treatment period.

4.5.2 Hospitalisation due to bodily injury and consequential work inability
If the policy stipulates the insurance in the event of hospitalisation in the form of daily benefit as a result of bodily injury and a consequential work inability and if the insured sustains bodily injury within the period of insurance, as a direct result of which, independently of any other circumstances, the insured is within 30 days from the date of the bodily injury hospitalised for a period longer than the franchise stated in the policy, the insurer shall make the insurance payment specified in the policy to the insured for each day of hospitalisation and for the days of work inability and treatment due to the bodily injury but for no longer than for the period specified in the policy as the maximum treatment period. The days of consequential work inability after the hospitalisation is finished, which are counted in for the purpose of the insurance payment, shall not exceed three times the number of days of hospitalisation unless otherwise stated in the policy.

4.5.3 Hospitalisation due to bodily injury or sickness
If the policy stipulates the insurance in the event of hospitalisation in the form of daily benefit in the event of hospitalisation as a result of bodily injury or sickness and if the insured sustains bodily injury or contracts a sickness within the period of insurance, as a direct result of which, independently of any other circumstances, the insured is within 30 days from the date of the bodily injury or the beginning of sickness hospitalised for a period longer than the franchise stated in the policy, the insurer shall make the insurance payment specified in the policy to the insured for each day of hospitalisation but for no longer than for the period specified in the policy as the maximum treatment period.

4.5.4 Hospitalisation due to bodily injury or sickness and consequential work inability
If the policy stipulates the insurance in the event of hospitalisation in the form of daily benefit as a result of bodily injury or sickness and a consequential work inability and if the insured sustains bodily injury or contracts a sickness within the period of insurance, as a direct result of which, independently of any other circumstances, the insured is within 30 days from the date of the bodily injury or the beginning of sickness hospitalised for the period longer than the franchise stated in the policy, the insurer shall make the insurance payment specified in the policy to the insured for each day of hospitalisation and for the days of work inability and treatment due to the bodily injury or sickness but for no longer than for the period specified in the policy as the maximum treatment period. The days of consequential work inability after the hospitalisation is finished, which are counted in for the purpose of by the insurance payment, shall not exceed three times the number of days of hospitalisation unless otherwise stated in the policy.

4.5.5 Only one type of insurance set out at the sections 4.5.1 to 4.5.4 above may be agreed in a single policy.

4.5.6 If, within a period of 60 days from the date of the hospitalisation, the insured is re-hospitalised due to complications arising from the same bodily injury or sickness, such re-hospitalisation shall be deemed to constitute one and the same insured event and eventual franchise will be used only once.

4.5.7 The insurance payment shall be paid at the end of hospitalisation. If hospitalisation continues for a period longer than 30 days, the insurer shall make an appropriate advance payment of the insurance payment upon application by the insured.

4.6 Daily benefit for emergency treatment as a result of bodily injury and/or sickness
4.6.1 If the policy stipulates the insurance in the event of emergency treatment in the form of daily benefit as a result of bodily injury and/or sickness if the insured sustains bodily injury or contracts sickness within the period of insurance, as a direct result of which, independently of any other circumstances, the insured suffers from work inability and receives treatment as a result of bodily injury and/or sickness within a period longer than the deductible specified in the policy, the insurer shall make the insurance payment specified in the policy to the insured for each day of the insured
work inability commencing on the first day of work inability after the expiry of the deductible, but for no longer than for the period specified in the policy as the maximum treatment period, less the deductible.

4.6.2 If the period of work inability exceeds the usual period required for the emergency treatment of the bodily injury or sickness, the insurer shall make the decision on the scope of the insurance payment on the basis of medical assessment of a physician designated by the insurer.

4.6.3 If the bodily injury or sickness as a result of which the insured receives treatment within the period of work inability relates to an injury or other damage to the spinal column and muscular girdle, nervous system and blood supply to the spine which is not detectable by radio-diagnostic or radioisotopic methods, the insurer shall make the insurance payment in respect of a maximum period of 35 days.

4.6.4 The insurer shall make the insurance payment in arrear once the work inability ends. If the work inability exceeds 90 days, the insurer may make reasonable advance of the insurance payment, if the insured so requests.

4.6.5 The period necessary for treatment of the consequences of bodily injury and/or sickness shall include any periods during which the insured was receiving occasional medical examinations or rehabilitation treatment aimed at alleviation of subjective difficulties.

4.6.6 If the insurance is agreed merely for daily benefit in case of sickness, the insurer shall not make the insurance payment for any consequence of bodily injury and vice versa.

4.6.7 If a daily benefit during the treatment in respect of sickness is expressly specified in the policy, the insurer shall make no insurance payment for work inability caused by any injury and vice versa.

4.6.8 The amount of daily benefit is 60% of the insurer's average gross daily earnings and shall not exceed the limit of insurance payment stipulated in the policy, unless the policy specifies otherwise.

4.7 Fractures

4.7.1 If the policy stipulates the insurance of fractures caused by bodily injury and if, within the period of insurance, the insured sustains bodily injury as a direct result of which, independently of any other circumstances, results in a fracture specified in the table of benefits or in the policy within 30 days from the date of the bodily injury, the insurer shall make the insurance payment specified in the policy, provided that the fracture is duly diagnosed and treated by a physician.

4.7.2 The amount of the insurance payment shall be calculated as the sum insured multiplied by the applicable percentage rate specified in the table of benefits for fracture in question.

4.7.3 If the same bodily injury causes more than one fracture, the total insurance payment shall be specified as an aggregate of all sums related to each individual fracture, but shall not exceed the limit of the insurance payment.

4.7.4 No claim for insurance payment arises in the event of pathological fractures.

4.8 Burns

4.8.1 If the policy stipulates the insurance of burns caused by bodily injury and if, within the period of insurance, the insured sustains bodily injury, independently of any other circumstances, results in a second or a higher degree burn specified in the table of benefits, the insurer shall make the insurance payment specified in the policy, provided that the burn is duly diagnosed and treated by a physician.

4.8.2 The amount of insurance payment shall be calculated as the sum insured multiplied by the applicable percentage rate specified in the table of benefits.

4.9 Surgical treatment

4.9.1 If the policy stipulates the insurance of surgical treatment caused by bodily injury and/or sickness and if, within the period of insurance, the insured sustains bodily injury and/or sickness as a direct result of which, independently of any other circumstances, the insured is within 30 days from the date of the bodily injury or the beginning of sickness hospitalised and has surgical treatment administered by a physician, the insurer shall make the insurance payment specified for surgical treatment.

4.9.2 The amount of insurance payment shall be calculated as a sum insured multiplied by the applicable percentage rate specified in the table of benefits.

4.9.3 If more surgical treatments are administered in the course of a single operation, insurance payment shall be made only for the surgical treatment with the highest percentage rate.

4.9.4 Insurance payment in the event of surgical treatment covered by the insurance but which is not
specified in the table of benefits for surgical treatment shall be determined by the insurer with reference to the degree of seriousness thereof and the data set out in the table of benefits, depending on the degree of difficulty of the treatment. A physician designated by the insurer shall access the degree of difficulty.

4.9.5 If the insurance is agreed merely to cover surgical treatments for consequences of bodily injury, there is claim for insurance payment in the event of surgical treatment in connection with any sickness and vice versa.

4.10 FUNERAL EXPENSES

4.10.1 If the policy stipulates the insurance of funeral expenses and the insured sustains a bodily injury or sickness as a direct result of which and independently of any other circumstances the insured dies within one year from the date of bodily injury or sickness and the beneficiary incurs expenses for the funeral of the insured, the insurer shall reimburse duly documented, adequate and reasonable expenses of the insured’s funeral, up to the sum insured.

4.10.2 If the policy only stipulates insurance of funeral expenses caused by a bodily injury, there is no entitlement to claim funeral expenses in the event of death of the insured as a result of any sickness.

5. EXCLUSIONS

5.1 The insurance according to these conditions does not apply to any loss caused directly or indirectly by:
   a) war circumstances;
   b) violent circumstances;
   c) terrorism;
   d) being on active service with armed forces of any state;
   e) using, releasing or leakage of substances, which directly or indirectly cause a nuclear reaction, radiation or radioactive pollution;
   f) dispersal, application or release of harmful, pathogenic or malignant biological or chemical materials.

5.2 The insurance also does not cover any bodily injury and other loss sustained by the insured: a) while travelling on an aircraft not registered to an official airline company, or on a flight which is not listed as a regular flight in the flight table or if the insured is not listed as a duly paying passenger;
   b) while participating in professional sporting activities (races, competitions including preparation and training), while participating in organized sporting competitions and in connection with hazardous sports;
   c) while participating in a race or competition of motor vehicles on land, water or air; including test rides;
   d) while directly participating in violent riots and disturbances, civil commotions or while disturbing a public order;
   e) while driving a motor vehicle without an appropriate driving licence or under the influence of alcohol, if the volume of alcohol in blood exceeds the limit stipulated by legal regulations;
   f) as result of criminal offence committed by the insured.

5.3 The insurance also does not cover bodily injuries, sicknesses and other loss, which the insured sustains in direct or indirect connection with:
   a) wilful or deliberate exposure of the insured to the danger (except in an attempt to save a human life), commitment of intentional self-inflicted injury, suicide or attempt thereat or nonadherence to medical advice without regard to the mental condition of the insured;
   b) circumstances, which existed prior to the policy conclusion and prior to the beginning of the insurance;
   c) acquired immunity deficiency syndrome (AIDS) with a positive laboratory test of the HIV virus presence or any of the derivatives or variations thereof howsoever acquired; in case of reasoned suspicion the burden of proof will be upon the insured to show that bodily injury or sickness was not caused by or did not arise through AIDS or HIV;
   d) venereal disease or their accompanying symptoms and sicknesses;
   e) mental, psychological or neurological sicknesses and defects and their treatment;
   f) research, tests, interventions, surgery or other activities of a purely cosmetic nature, vaccination, obesity, impotence, infertility, artificial insemination, conception control,
abortion and childbirth;
g) use of alcohol or application of drugs or other narcotic or addictive substances by the insured unless they were prescribed by a physician.

5.3.1 If it is agreed in the policy that some exclusions shall not be applied it does not influence the application of other exclusions. Other exclusions can be agreed on in the policy or the stated exclusions, can be amended.

6. RIGHTS AND OBLIGATIONS OF PARTIES

6.1 The policyholder is obliged to acquaint the insured with the content of the policy.

6.2 The policyholder and insured are bound according to the statutory rules to answer truthfully and in full all written questions of the insurer in relation to the policy and inform the insurer about all circumstances, which are known and important for an appraisal of the insured peril. This obligation shall also apply to any change in the policy.

6.3 The policyholder shall inform the insurer preferably in advance otherwise without undue delay about all changes which occur during the policy period in the information provided to the insurer before the policy was concluded, in particular the insured activities, contact address, headquarters or home address and telephone number.

6.4 The insurer may, on the basis of the statutory rules, withdraw from the policy if the policyholder or the insured breaches its obligations pursuant to section 6.2 provided that the insurer would not have concluded the policy had the questions been answered truthfully and in full.

6.5 The insurer may proportionally reduce the insurance payment in case that a lower premium was calculated by the insurer where such a calculation of the premium was a consequence of a breach by the policyholder or the insured of statutory rules, obligations set out in these conditions or in the policy.

6.6 If a breach of the statutory rules, these conditions or the policy had a material influence on occurrence of the insured event, or had an influence on its course or aggravation of its consequences or the ability of the insurer to assess the amount of the insurance payment, the insurer may reduce the insurance payment pro-rata to the impact of such breach on the scope of its obligation to make the insurance payment.

6.7 Pursuant to the provision of § 24 of the Act on Insurance Contract, the insurer is entitled to refuse the insurance payment under the policy if the insured event occurred during change of the job or in the course of activities other than stated by the insured at the time of the conclusion or change of the policy.

6.8 The insurer shall make the insurance payment according to the policy under the condition that the insured:

a) used all reasonable efforts to ensure that the insured event did not occur;

b) did not violate statutory duties aimed at averting an impending loss or reducing the danger which could cause the occurrence of an insured event;

c) made all reasonable efforts to reduce loss arising or potentially arising from an insured event;

d) made it possible for the insurer to inspect and examine the insured peril and afforded him the necessary cooperation and information for the assessment of the insured peril assessment.

If it is proven that a breach of the above conditions had an influence on the occurrence of the insured event, extent or amount of damage, the insurer may reduce the insurance payment prorata to the impact of such breach on the scope of his obligation to pay.

6.9 The insurer is entitled to request information about the insured’s state of health, including information related to his state of health before the policy was concluded, and to request that the insured be examined by a physician or in connection with assessment of his health or cause of death, in relation to the assessment of insured risk, the premium and the investigation of the insured event. The insurer shall open the investigation of the insured event and will provide the insurance payment only under the condition that the insured grants his/her consent under the Act No. 101/2000 Coll. on protection of personal data and sensitive data, as amended.

6.10 The insured is obliged to grant his/her consent to physicians, medical facilities, facilities providing medical care by which he/she was treated to issue medical reports, make copies of medical documents or to lend such documents to the insurer and release the insurer from the duty of confidentiality. The insurer will commence the investigation of the insured event and make the
insurance payment only on the condition that the insured will grant the above mentioned consent and release physicians and medical facilities from the duty of confidentiality in respect to information related to the insured. Only the physician nominated by the insurer is authorized to provide an assessment of the cause of the insured event and its consequences, eventually of other facts which are essential for determination of the scope of the insurance payment.

6.11 The insurer is entitled not to make the insurance payment if the bodily injury of the insured has been incurred in connection with acts of which the insurer has been convicted as deliberate criminal offence or by which the insured intentionally suffered self-inflicted bodily injury. If criminal proceedings are pending, the insurer will make the insurance payment only after final binding verdict of not guilty is issued.

7. INSURANCE PAYMENT

7.1 The insurer shall make the insurance payment under the policy for all insured events that occur during the policy period. However the total insurance payment provided for the insured event is limited by the limit of insurance payment stated in the policy. The policy may set out limit of insurance payment for specific parts of the insurance payment (sublimits). The total limit of insurance payment is a limit for the sum of all eventual insurance payments including all insurance payments, which are subject of sublimits. The sublimits are limits for the sum of the concrete type of insurance payments.

7.2 The insurance payment is payable within 15 days after the completion of investigation necessary to determine the reason and the amount the insurer is obliged to pay. The insurance payment is payable in Czech currency unless otherwise agreed in the policy. The “average exchange rate” published by the Czech National Bank on the date of the insured event, is decisive for conversion of a foreign currency to Czech currency.

7.3 Insurance payment in excess of 50,000.00 CZK will be made entirely by a bank transfer.

7.4 The consequences of the bodily injury or sickness, which are not stated in the policy or in the tables of benefits, are not a subject of this insurance unless the policy or the conditions set out otherwise.

7.5 The upper limit of the sum of all insurance payments which the insurer will make in case of a death as a result of a bodily injury, of a total permanent disability as a result of a bodily injury or (a serious) permanent physical dismemberment as a result of a bodily injury or while two or more insureds are injured and they have one common policy, if one and the same incidental event was a cause of such bodily injuries, the accumulated limit of insurance payment is set out in the policy. If a sum of such insurance payments exceeds the accumulated limit of insurance payment, the insurer will provide to each of the insureds only a pro-rata insurance payment the sum of which will correspond to the amount of the accumulated limit of insurance payment.

7.6 If concurrence of claims for insurance payment for a death due to bodily injury, total and permanent disablement due to bodily injury or (serious) permanent dismemberment due to bodily injury occurs, the insurance payment shall be made according to one of the following options:

a) if the bodily injury causes death of the insured before the insurance payment for (serious) permanent dismemberment, respectively total and permanent disablement has been made to him, only the insurance payment for death shall be made to him, even if the insurance payment for death due to bodily injury is lower than the insurance payment for (serious) permanent dismemberment or total and permanent disablement;

b) if the insured has already received the insurance payment for (serious) permanent dismemberment or total and permanent disablement and after that dies as a result of the same bodily injury, the insurance payment for death shall be lowered by the already made insurance payment for (serious) permanent dismemberment or total and permanent disablement;

c) if the insured has already received an insurance payment for (serious) permanent dismemberment, and after that he becomes permanently and totally disabled as a result of the same bodily injury, the insurance payment for total and permanent disablement shall be lowered by the already made insurance payment for (serious) permanent dismemberment.

7.7 Disappearance of the insured

a) If the body of the insured is not found within 365 days from his/her disappearance in the course of forced landing, wrecking or accident of the means of transport by which the insured is proven to have travelled, such situation shall be for insurance purposes regarded
as death due to bodily injury.

b) The insurer shall provide the insurance payment only if the beneficiary submits a decision of a relevant judiciary or other body, declaring the insured dead. If it later turns out that the insured was or is still alive, the beneficiary is obliged to return the provided insurance payment without delay to the insurer.

7.8 If the consequences of the bodily injury or sickness deteriorate as a result of previous state of health of the insured or as a result of his refusal or breach of an appropriate medical treatment, the respective insurance payment shall be calculated according to the consequences of bodily injury or sickness, which would be suffered by an ordinary healthy person, had the person undertaken an appropriate medical treatment.

7.9 To exclude any doubt, it is stressed that the insurance payment is not in any way derived from granting or the refusal to grant disability pension according to the social security regulations.

8. CLAIM FOR INSURANCE PAYMENT

8.1 If the insured dies, the policy holder or other beneficiary is obliged to report this event to the insurer by telephone within three working days. However, if the policyholder or other beneficiary complies with this requirement, they are not relieved of the duty to report the insured event within the period and in form set out in the following provisions.

8.2 The insured or other beneficiary must immediately, at the latest within 30 days from the date of the occurrence of the bodily injury or commencement of the sickness, respectively from the date when consequences of the bodily injury or sickness arise, if these occur later. If it is not possible to supply all of the documents set out in the section 8.4 within this period and the reasons thereto are justified, the insured or other beneficiary shall make the notification of the insured event as soon as it becomes possible to obtain the missing document.

8.3 The notification of the loss event must be made by the insured or other beneficiary in writing, at their own expenses and in the form set out in the section 8.4 and must be delivered to the insured.

8.4 Notification of any loss event must include:

8.4.1 General information:

a) policy number, or insurance certificate in case of an individual insurance;

b) medical report confirming nature and scope of all bodily damage or course of sickness and containing exact diagnosis.

c) an officially certified copy of the death certificate and legal documents establishing the identity of all beneficiaries;

8.4.2 Specific information related to the loss event

a) the insurer shall require on its forms further information necessary to investigate the respective loss event according to its nature

b) the insurer has the right to demand also other documents, such as police report on the accident etc.

8.4.3 Consent in writing with processing of personal data and sensitive personal data as described in section 6.9 and written consent and release of confidentiality as described in 6.5.

8.5 The insured is obliged to prove what circumstances have lead to occurrence of the insured event and what was its main cause. If the insured dies, this obligation passes to the beneficiaries.

8.6 The insurer is entitled to examine the state of health of the insured and require medical examination of the insured. The expenses of such examinations shall be bear by the insurer. The insurer shall however not cover these expenses if they have been incurred in relation to an unjustified claim for settlement of the insured event or if a fraudulent intention of the insured has been discovered. If the insured dies, the insurer is entitled to perform examination or autopsy. The examination or the autopsy shall be performed at the expense of the insurer and in such a scope and frequency, which the case requires according to the insurer’s opinion.

8.7 In case of the insured event, the insured or other authorized person is obliged to enable the insurer an access to investigation or other similar file of the policy or file or other administrative body and provide copies of documents contained in these files.

9. CHANGE OF RISK

9.1 The policyholder is obliged to notify the insurer of any change of the insured risk (especially the change of the insured activity, the place of its performance etc.) compared to the risk notified to the insurer at the time of the conclusion or change of the policy.

9.2 In case of an increase in the insured risk, the insurer has the right in accordance with statutory
rules to demand increase of the insurance payment.
9.3 The policyholder is obliged to inform the insurer about the level of the insured risk in the next period of insurance, at latest until the end of the present period of insurance.
9.4 After re-valuation of the insured risk expected in the next period of insurance by the insurer, the parties shall proceed in the following way:
a) in case the insured risk is the same as in the previous period of insurance, conditions set out in the policy shall remain the same in the following period of insurance;
b) in case the insured risk changes substantially, the insurer shall propose a change of the policy. In case the agreement concerning the change of the policy is not reached at latest within one month after the previous period of insurance, the insurer is entitled to terminate the policy.
10. WAITING PERIOD
10.1 Waiting period can be arranged in the policy. Waiting period begins to run on the first day of the insurance and amounts to 60 days if not otherwise stated in the policy. If during the waiting period an event occurs, which would otherwise be an insured event, the insurer cannot claim insurance payment in connection with such event.
10.2 Waiting period shall however not apply to insurance of consequences of bodily injury.
11. PREMIUM
11.1 Amount of premium is stated in the policy and is determined according to the scope of insurance on the basis of assessment of the risk insured and the sum insured.
11.2 At the end of the period of insurance the policyholder is obliged to supply the information required by the insurer to account the previous period of insurance and to determine premium for the next period of insurance.
11.3 If a current premium is agreed in the policy, it is payable for every policy period always on the first day of the policy period unless different due date or payment of the premium by instalments. If the policy sets out a lump-sum premium payable on the day of inception of the insurance, unless the policy stipulates different due date. It may be agreed in the policy that the policyholder shall pay lump-sum or current premium in instalments.
11.4 If the policyholder fails to pay the premium in due time it shall pay to the insurer interest on the overdue amount at the applicable statutory rate.
11.5 The insurer may set off unpaid premium including interest one overdue amount against the insurance payment. The insurer shall deduct eventual excess premium from the premium for the next period or return it to the policyholder.
11.6 If agreed in the policy, the insurer may fully or partly relieve the insured of his obligation to pay the premium for a period agreed in the policy and this will not have an effect on the amount of insurance payment stated in the policy.
11.7 without affecting the amount of premium stated in the policy.
12. INSURANCE SUSPENSION
12.1 If the premium or its individual instalment is not paid within two months from the day of its maturity, the insurance is deemed to be suspended. While the insurance is suspended, there is no obligation to pay the premium and no right to claim insurance payment as a result of loss events, which would otherwise be insured events.
12.2 If the insurance is suspended, the policyholder is obliged to pay the insurer a penalty amounting to 1/365 of the annual premium for every day of insurance suspension.
12.3 A different period whose elapsing will cause the insurance to be suspended.
13. INCEPTION AND TERMINATION OF THE INSURANCE
13.1 The policy stipulates whether the insurance is agreed to be for a definite period, indefinite period or definite period with automatic extension.
13.2 If the insurance is concluded by means of distant communication, the policy shall come into existence at the time of payment of the first premium. The insurance shall have in this case retroactive effect as of the day following the first telephone contact between the insurer and the policyholder concerning the conclusion of the policy.
13.3 The insurance begins at 0.00 of the day specified in the policy as the first day of the insurance.
13.4 If the insurance is written for definite period of time, it shall terminate at 24.00 on the day specified in the policy as the last day of the insurance.
13.5 The insurance will further terminate:
a) on the basis of an agreement in writing between the insurer and the policyholder;
b) through termination by a notice delivered by either party pursuant to the statutory rules;
c) through withdrawal according to the relevant statutory rules;
d) pursuant to the relevant statutory rules, on the basis of a default in paying the premium;
e) and in other cases set out in the statutory rules;

13.6 It is possible to agree in the policy, that the insurance covers the period before the policy was concluded. The insurer is not obliged to make insurance payment if the insured knew or could have known that the insured event had already occurred, at the time when the draft policy was submitted. The insurer is not entitled to receive any premium if he knew or could have known that the insured event could not occur at the time when the draft policy was submitted.

13.7 Claim for “payment of reminder” does not arise at the termination of the insurance.

14. NOTICES

14.1 Any notice or other communication under the policy shall be delivered to the address set out in the policy.

14.2 Any notice or other communication to be served under the policy to the policyholder, the insured or the beneficiary, shall be deemed to have been served at the moment of receipt of the notice by the addressee or at the moment when the addressee refused or otherwise precluded the receipt of the notice (e.g. because have not notified a change of its address).

15. SUBROGATION, ASSIGNMENT OF RIGHTS

15.1 If the insurance is concluded as an “amount insurance”, then the right of the insured for damages or any other right against the person liable for the damage is not affected by the right to claim the insurance payment from the insurer.

15.2 If the insurance is concluded as a “loss insurance”, then the right of the insured for damages as a result of insured event against other person or other similar right shall pass on the insurer as soon as it makes the insurance payment, and up to the amount of the insurance payment made by the insurer. The insurer is obliged to take all measures aimed at securing the rights of the insurer towards other parties. The insurer is entitled to assign rights to other person, which in compliance with these provisions have passed on to him or any other rights from the policy.

15.3 No rights under the policy may be assigned to other person without the prior written consent of the insurer.

16. TERRITORIAL SCOPE OF THE INSURANCE

The insurance applies to insured events occurring anywhere in the world unless otherwise specified in the policy.

17. GOVERNING LAW

The policy is governed by the Czech law.

18. DISPUTES SETTLEMENT

18.1 Any dispute, claim or point subject to debate between the parties in connection with this agreement (including issues relating to its validity, effect and interpretation) shall be referred for resolution to the relevant court in the Czech Republic.

19. SEVERABILITY

19.1 If any provision of the conditions or policy becomes or will be found invalid or unenforceable, that shall not affect the validity and enforceability of any other provision of the conditions unless such invalidity materially influences the meaning of other provisions in such manner that one of the parties would have not entered into the policy under such conditions.

19.2 In the case above the policyholder and the insurer undertake to act in good faith in order to replace the invalid or unenforceable provision by another provision, which would have a similar effect.

20. MISCELLANEOUS

20.1 The insurance is concluded as an “amount insurance”. It is however possible to agree in the policy that a specific type of insurance is concluded as a “loss insurance”.

20.2 The policy may only be amended in writing, by amendments executed by both contractual parties. Unless stated otherwise in the policy or in these conditions, all acts relating to the policy must be in writing at the address of the counterparty set out in the policy.

20.3 The headings of paragraphs and sections in these conditions are for convenience only and shall not affect their interpretation or scope.

20.4 The policy may modify these conditions and such modification will prevail over these conditions.
such a modification aims at limitation of one of the exclusions set out in these conditions, such modification shall prevail only if expressly stated that the exclusion is not to be applied.

20.5 Tax aspects of the private insurance are regulated in detail in the law on income taxes No. 586/1992 Coll. Exception from income tax of the insurance payment is only possible under the conditions stated in §4 of this law. Procedural aspects of taxation

20.6 Tax aspects of the private insurance are regulated in detail in law on income tax no. 586/1992 Coll. Exception from income tax of the insurance payment is only possible under the conditions stated in §4 of this law. As far as the procedure is concerned, tax aspects are regulated particularly by the law of tax and fees administration no. 337/1992 Coll.

20.7 The policyholder, the insured or the beneficiary may send complaints addressed to the insurer. It is also possible to make complaints to the Ministry of Finance of the Czech Republic, which is a state supervision body in relation to activities of the insurer’s business activities.

20.8 If the means of distant communication are used for the conclusion of the policy, no other fees will be charged by the insurer, apart from the premium. The policyholder is responsible in such a case for his own telecommunication costs at the relevant rates.

1 There are irreconcilable differences between the languages of Czech and English and between legal concepts. Even the best translation may result in misunderstanding. This translation was prepared with the aim of providing the best understanding of the Czech meaning, so it may not use the exact industry terms in some places. If an uncertainty arises about the meaning of any section, please ask for clarification.