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Accident Insurance General Terms and Conditions

OPENING PROVISIONS

Article 1

(1) These Accident Insurance General Terms and Conditions, (hereinafter: General Terms and Conditions) constitute an integral part of the accident insurance contract (hereinafter: insurance contract), entered into by the policyholder and the Joint Stock Insurance Company (hereinafter: Insurer).

(2) Certain terms in these General Terms and Conditions shall have the following meaning:
- **"Insurer"** – a joint stock insurance company which is obliged by the insurance contract, in case the insured event occurs, to pay the agreed sum insured, i.e. the indemnity to the insured person;
- **"Applicant"** - a person who wants to enter into an insurance contract, and for that purpose submits a written or oral application to the Insurer;
- **"Policyholder"** – a person who enters into an insurance contract with the Insurer;
- **"Insured"** – a person on whose death, loss of general capability to work, inability to work or health problem, depends the payment of the sum insured, or the indemnity;
- **"Beneficiary"** – a person in whose favor the insurance contract is entered into;
- **"Policy"** – a document that is considered evidence of the signed insurance contract;
- **"Cover note"** – a temporary evidence of the signed insurance contract, which contains essential elements of the contract;
- **"Premium"** – the amount that the Policyholder must pay after the Insurance contract is signed;
- **"Sum insured"** – the highest amount which the Insurer is required to pay in case the insured event occurs;
- **"Insured event"** – an event that is covered by the insurance contract, which must be future event, uncertain and independent of the will of the Policyholder.
- **"Waiting period"** - an agreed period that starts on the day when the temporary inability to work occurred and must be expired so that the Insurer can determine the validity and the scope of its liabilities. In such a case, the Insurer shall be held liable only if the temporary inability to work lasts even after the expiry of the waiting period and is being determined starting from the first day of the temporary inability to work;
- **"Stipulated disability table"** – a table which is used to determine the percentage of permanent loss of general work capabilities (disability) of the insured person as a result of an accident that depends on the selected insurance coverage agreed by the Policyholder, which is defined and specified in the insurance policy (hereinafter: disability table).

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Article 2

(1) Under the insurance contract, the Policyholder shall be required to pay the premium, while the Insurer shall be required, in case the insured event occurs, to pay the sum insured to the insurance beneficiary, i.e. part of it.

(2) These General Terms and Conditions shall regulate the relations between the Policyholder and the Insurer, in compliance with the agreed forms of insurance, in the event of:
1) accidental death;
2) permanent loss of general work capability (disability);
3) temporary inability to work (daily benefit);
4) health problems which require medical attention (medical expenses and hospital days);
5) other agreed events shall be regulated by the additional terms and conditions.

(3) Permanent loss of general work capability (disability) can be agreed:
a. According to the linear method for calculating the payment of the sum insured (hereinafter: linear disability) in accordance with Article 8, paragraph (1), item 1), sub – item 1. and item 2).
b. According to the progressive method for calculating the payment of the sum insured (hereinafter: progressive disability) in accordance with Article 8, paragraph (1), item 1), sub – item 2. and item (2).

(4) If it is not expressly stated in the insurance contract that progressive disability is agreed, it shall be considered that linear disability is agreed.

(5) Permanent loss of general work capability can be agreed by excluding Insurer's liability if the accident resulted in certain percentage of disability below the determined percentage (hereinafter: exclusion of certain percentages of disability), which must be defined and specified in the insurance contract.

(6) Temporary inability to work can be agreed with payment of daily benefits:

a. for each day of the temporary inability to work, in accordance with Article 15, paragraph (9), (10) and (14);
b. for previously determined number of days necessary for treatment as a result of an accident, in accordance with the Table for determining the number of days necessary for treatment as a result of an accident, regardless of the actual duration of the treatment (hereinafter: payment of daily benefits for previously determined number of days necessary for treatment), in accordance with Article 15, paragraph (11), to (14).

(7) If it is not expressly agreed in the insurance contract upon the payment of the daily benefits for previously determined number of days necessary for treatment, it shall be considered that temporary inability to work is agreed with payment of daily benefits for each day of the temporary inability to work, in accordance with Article 15, paragraph (9), (10) and (14).

(8) Temporary inability to work, as defined in paragraph (6), item a., may be agreed with a waiting period, which must be precisely defined in the insurance contract.

(9) All notifications and applications which the contracting parties are required to make, in accordance with the provisions of these General Terms and Conditions, need to be confirmed in writing if made orally, by telephone or otherwise.

(10) Date of receipt of the notification or of the application shall be the day when the notification or the application is received. If the notification or application is sent by registered mail, the day of receipt shall be the date it is delivered to the post office. The agreements relating to the content of the insurance contract shall be valid only if entered into in writing.

Entering into an Insurance Contract

Article 3

(1) The insurance contract shall be signed based on an oral or written application.

(2) The Insurer may require prior written offer from the applicant on a separate form.

(3) If the Insurer refuses to accept the written application, than the Insurer shall be required to notify the applicant thereof, in writing, within 8 (eight) days of its receipt.

(4) If the Insurer has not rejected the application which is not inconsistent with the insurance terms and conditions, nor has requested additional explanations within the period provided for in the preceding paragraph, it shall be considered that the insurance was entered into on the day the Insurer received the application.

(5) If the Insurer accepts the application only under special terms and conditions, the insurance shall be entered into on the day the applicant has agreed to accept the amended terms and conditions.

(6) It shall be considered that the applicant has refused to enter into a contract if he does not agree to the amended terms and conditions within 8 (eight) days from the day of receipt of the notification from the Insurer sent via registered mail.

(7) The insurance contract shall be considered concluded when the Policyholder and the Insurer sign the insurance policy or the cover note.

(8) The contractual relationship resulting from the insurance may also arise from the payment of the premium, if the Terms and Conditions provided for in the Decision of the Insurer are met.

(9) The Policyholder shall be required, upon the conclusion of the insurance contract, to inform all insured persons on the contents of these General Terms and Conditions and on the contents of the notification concerning the procession of data of the Insured provided by the Insurer.

Insurance Eligibility

Article 4

(1) As a rule, persons at the age of fourteen to the age of seventy-five shall be considered eligible for insurance. Persons under the age of fourteen and older than seventy-five years may be insured only if this is provided for in the special or additional terms and conditions, i.e. in the insurance contract.

(2) Persons whose general work capability is impaired due to a serious illness, serious physical defects or deficiencies, shall be insured by payment of higher premiums as provided for in Article 9, paragraph (2) hereof.

(3) Incapacitated persons shall be ineligible in any case, unless it is provided otherwise by law.

Meaning of the Term Accident

Article 5

(1) Accident, within the meaning of these General Terms and Conditions, shall be considered any sudden event, independent of the will of the Insured, which having mainly external effect and suddenly affects the body of the Insured has resulted in his death, total or partial disability, temporary inability to work or health problems which require medical attention, i.e. other consequences provided for in the additional terms and conditions.

(2) In accordance with the preceding paragraph, especially the following events shall be considered as accident: suffocation, collision, strike by an object or in an object, electric shock or lightning, fall, slip, push, injury caused by weapons, various other objects or explosive materials, stab by an object, attack or bite by animals and insect bite, except it has caused an infectious disease.

(3) The following shall also be considered as accident:
1) Poisoning by chemical agents;
2) Infection of the injury caused by the accident;
3) Poisoning due to inhalation of gases or toxic vapors;
4) Burns caused by fire or electricity, hot objects, liquid or steam, acids, bases, etc;
5) Drowning;
6) Choking or suffocation due to flooding will huge quantity of soil, sand, etc., as well as due to inhalation of vapors and gases;

7) Muscle rupture, dislocation, rupture of joints, healthy bone fractures due to sudden bodily movements or sudden stress caused by unforeseen external circumstances, and if it is immediately after the injury determined in the hospital or in other medical institutions;
8) Effects of light, sunlight, temperature or bad weather conditions, if the Insured was exposed directly to one of these sources after a prior accident, or he found himself in such unanticipated circumstances he could not prevent, or was exposed to them after the rescue of a human life;
9) Effects of X-rays and radium therapy, if they occur unexpectedly.

(4) Within the meaning of these General Terms and Conditions, the following shall not be considered an accident:
1) All infectious, occupational and other diseases, as well as the consequences of the psychological impact;
2) Abdominal hernia, navel hernia, liquid and other hernias, other than those incurred by the direct damage to the abdominal wall under direct impact of external mechanical forces on the abdominal wall, if after the injury traumatic hernia was established, and medically, in addition to the hernia, if damage to the soft parts of the abdominal wall in that particular area was established;
3) Infections and illnesses that occur due to various forms of allergies, cutting or tearing calluses and other rough skin excrescences;
4) Anaphylactic shock, unless it is a result of the treatment after the accident;
5) Hernia disci intervertebralis, all kinds of lumbalgia, discopathy, spondylosis, spondylolisthesis, spondylolysis, sacralgia, myofascitis, coccydynia, sciatica, fibrositis, fasciitis, and all kinds of patho-anatomic changes of the sacrum - lumbar region marked by analogous terms;
6) Retinal detachment (ablatio retinae), unless it was incurred as a direct injury of the previously normal eye, medically diagnosed;
7) Consequences manifested at the Insured due to delirium tremens and effects of the narcotics;
8) Consequences resulting from medical, especially surgical procedures and operations undertaken as a treatment or prevention of diseases, unless such consequences occurred due to proven mistakes of the medical personnel (vitium artis);
9) Pathological changes seen in the bones and pathological Salter-Harris fractures;
10) Systemic neuromuscular diseases and endocrine diseases.

Duration of the Insurance Contract

Article 6

(1) The insurance contract shall be entered into:
1) With a definite duration, for a period of one year or less – hereinafter: short-term insurance;
2) With an indefinite duration which can be renewed every year unless one of the contracting parties terminates it in writing no later than three months before the expiration of the current insurance year – hereinafter: perpetual insurance.
In insurance policies of this kind, only the insurance inception date shall be designated;
3) With a definite duration, for a period exceeding one year or several years – hereinafter: long-term insurance.

(2) The insurance contract shall start at 24.00 on the date designated in the insurance policy as an inception date of the Insurance contract, unless it is otherwise stipulated in the additional terms and conditions or it is otherwise agreed upon in the insurance policy, and shall cease at 24.00 hours on the date agreed upon in the insurance policy as the date of termination of the insurance.

(3) The insurance contract shall cease, for each Insured, at 24.00 regardless whether and how the duration is agreed upon, on the date when:
1) Death or 100% disability of the Insured occurs;
2) The Insured becomes incapable to work, in accordance with Article 4, paragraph (3) hereof;
3) The insurance year in which the Insured reaches 75 years of age expires;
4) The deadline set forth in Article 11, paragraph (3) hereof passes, and if by that time the premium is not paid and the insurance contract is terminated, in accordance with Article 18 hereof.

Commencement and Termination of Insurer's Liability

Article 7

(1) The liability of the Insurer to pay the agreed sum insured shall start at 24.00 on the date designated in the insurance policy as an inception date of the insurance contract, but not earlier than 24.00 on the date when the first premium is paid, unless it is otherwise provided for in the insurance policy or in the additional terms and conditions.

(2) The liability of the Insurer shall cease at 24.00 on the date designated in the insurance policy as the date of expiration of the insurance contract.

Scope of the Insurer's Liability

Article 8

(1) In case the insured event occurs, in accordance with these General Terms and Conditions, the Insurer shall pay the amounts agreed in the insurance contract, as follows:
1) Sum insured in case of death, if the death of the Insured is a result of an accident, i.e.:
   1. Sum insured in case of disability, if 100% disability of the Insured occurred as a result of an accident – if linear disability is agreed, or
   2. 200% of the sum insured in case of disability, if 100% disability of the Insured occurred as a result of an accident – if progressive disability is agreed;
2) Certain percentage of the sum insured in case of disability, which corresponds to the degree of partial disability, if partial disability of the Insured occurred as a result of the accident – if linear disability is agreed;

3) Certain percentage of the sum insured in case of disability which is a result of an accident, if disability of the Insured up to 50% occurred as a result of an accident, while the insurance indemnity for the percentage of disability exceeding 50% is determined in accordance with paragraph (2) of this Article, if progressive disability is agreed;
4) Daily benefit for each day of the temporary inability to work, in accordance with Article 15, paragraph (9), (10) and (14) of these General Terms and Conditions, if the accident resulted in temporary inability to work and if temporary inability to work was agreed with payment of daily benefits for each day of the temporary inability to work, and if it was agreed that waiting period should be applied;
5) Daily benefit for previously determined number of days necessary for treatment, in accordance with Article 15, paragraph (11) to (14) hereof, if the consequences occurred as a result of an accident, which is listed in the Table for determining the number of days necessary for treatment as a result of an accident (hereinafter: Table of daily benefits) - if temporary inability to work was agreed with payment of daily benefits for previously determined number of days necessary for treatment;
6) Reimbursement for medical expenses, in accordance with Article 15, paragraph (15) item 1 and paragraph (16) hereof, if the Insured, as a result of an accident, needed medical attention and treatment and if he had to pay for the subsequent medical expenses.
7) Reimbursement of medical expenses for a day at a hospital under Article 15, paragraph (15) item 2) hereof if due to an accident an Insured has spent time in an inpatient facility. Under these Terms and Conditions, inpatient facilities are trauma centers and other hospitals (orthopedic, neurosurgeries, etc.) which admit patients injured in accidents and rehabilitation facilities.
8) Other agreed liabilities in accordance with the additional terms and conditions.

(2) If progressive disability is agreed and if the percentage of the established disability of the Insured exceeds 50%, but is not higher than 75%, the percentage of indemnity paid by the Insurer shall be calculated in a manner that for every percentage of disability exceeding 50%, it shall double the amount of indemnity in case of disability. If the percentage of disability exceeds 75%, but is less than 100%, the percentage of indemnity paid by the Insurer shall be calculated in a manner that for every percentage of disability exceeding 50% but which is less than 75%, it shall double the amount of indemnity, and for every percent of disability exceeding 75% but which is less than 100%, it shall multiply four times the amount of indemnity in case of disability.

(3) The Insurer shall be held liable in accordance with paragraph (1) and (2) of this Article, only if the accident occurred within the agreed period of insurance. Insurer's liability shall be determined in compliance with the insurance policy which was valid on the date when the accident occurred. The agreed sum insured shall be the upper limit of Insurer's liability, which is not subject to revalorization.

(4) The Insurer shall be held liable, according to the preceding paragraph, if the accident occurred while performing the activities which are explicitly stated in the insurance policy (for example, while performing or not regular occupational activities, or only in one particular capacity as: athlete, hunter, driver or passenger in a motor vehicle, excursionist, firefighter, grenade and other explosive device dismantler, stuntman, etc.).

Limitation of the Insurer's Liability

Article 9

(1) Unless otherwise agreed and if the appropriate increased premium is not paid, the agreed sum insured shall be reduced proportionally to the premium which was to be paid according to the premium that was actually paid, in the event of an accident:
1) While managing and flying plane and air crafts of all kinds, as well as in sport parachute jumping, except as a passenger in public transportation;
2) While the Insured is doing trainings and taking part in public sporting events in the capacity of a registered member of sports organizations such as: football, ice hockey, Jiu-jitsu, judo, karate, boxing, skiing, rugby, wrestling, ski jumping, mountain climbing and underwater fishing, as well as automobile and motorcycle speed racing, motocross, and while doing such trainings;
3) War and armed conflict events in which the Insured is found outside of the territory of the Republic of Serbia, but only if the Insured did not take active part in these events;
4) Of persons who are considered abnormal risk due to the fact that they suffered a serious disease or were seriously ill or burdened with congenital or acquired physical defects or disabilities at the time the contract was signed.

(2) As abnormal risk referred to in item 4) of the preceding paragraph, shall be considered the persons who have shortcomings, defects or illnesses due to which their general capability to work is decreased for more than 50%, according to the table of disability provided for in these General Terms and Conditions, which is an integral part of the insurance contract.

Exclusion of the Insurer's Liability

Article 10

(1) The Insurer shall not be held liable, if the accident occurred:
1) As a result of natural disasters (earthquakes, floods, etc.)
2) As a result of war events, uprising, terrorist acts, insurrection, riot or unrest in the Republic of Serbia or active participation in such events outside of the territory of the Republic of Serbia;

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3) Due to active participation in armed actions, unless the Insured's participation in these events was a part of his job;
4) While managing aircrafts of all kinds, vessels, motor and other vehicles without the necessary official documents, which authorize the driver to manage and drive that kind and type of aircraft, vessel, motor and other vehicle.
The provisions set forth in item 4) of this paragraph shall not apply in cases in which the lack of necessary official documents did not affect the occurrence of an accident and the Insurer's liability. In accordance with these General Terms and Conditions, it shall be considered that the Insured has the necessary official documents when, for the purpose of preparing and taking exams for obtaining official documents, he drives the vehicle under direct supervision of an authorized official of professional instructor.
5) Due to attempted or performed suicide of the Insured by any reason;
6) Due to the fact that the Insured intentionally caused the accident;
7) Due to the fact that the insurance beneficiary intentionally caused the death of the Insured and if there are several insurance beneficiaries, only the insurance beneficiary who has intentionally caused the death of the Insured shall be excluded;
8) In preparation, attempt or commission of an intentional criminal act, as well as in case of fleeing after such actions;
9) Due to the causal relation of the effects of alcohol or narcotics to the Insured and the occurrence of the accident. It shall be considered that the accident is a result of the causal relation of the effects of alcohol on the Insured:
   – in the event of a traffic accident, if the driver of the motor vehicle, i.e. the Insured, at the time of the accident, had in his blood more than the allowed quantity of alcohol, according to the legal regulations in force at the time of the accident, and for professional drivers of motor vehicles, presence of alcohol in blood is not allowed (0.00 ‰);
   – if the alcohol test showed alcohol intoxication and the Insured did not cooperate in the analysis for determination of the precise degree of presence of alcohol in blood;
   – if the Insured refused or avoided the possibility of determining the degree of presence of alcohol in blood;
   – - if the Insured distanced himself from the site of the accident, or failed to call the police or inform the nearest police station about the accident;
10) Due to active participation in a physical confrontation, except in a proven case of self-defense;
11) If the physical defects occurred as a result of the treatment or operations performed by the Insured on his body, or if the Insured allowed such operations to be performed, which were not medically necessary, but were done for aesthetic reasons;
12) As a consequence of ionizing radiation or radioactive contamination from radioactive waste of burning nuclear fuels, or due to radioactive, toxic, explosive or other dangerous materials of explosive nuclear device or some of its components;
13) Due to a causal - consequence relation of the effects of abused medicament on the insured person and the occurrence of the accident. It shall be considered that the insured person abused the medicament in the following cases:
   – used the medicine for which there is no license for circulation issued, or the production and trading of that medicine is prohibited by law;
   – if the insured, when using the medicine, did not adhere to the instructions for patients/users, as a document that contains basic information about the prescribed medicine and its use.

(2) If it is agreed that certain percentages of disability shall be excluded, in accordance with Article 2, paragraph (5) of these General Terms and Conditions, the Insurer shall not be held liable in the event of a procedure for liquidation of the damage, if the Insurer, according to the table of disability and the attached documentation, determined that the disability of the Insured is equal to or lower than the percentage specified in the insurance contract as an excluded percentage of disability.

(3) If temporary inability to work with payment of daily benefit for previously determined number of days necessary for treatment is agreed, the Insurer shall not be held liable for those consequences resulting from the accident which are not listed in the Table of daily benefits.

(4) The Insurer shall not be held liable to indemnify the medical expenses determined in accordance with Article 15, paragraph (15) item 1) and paragraph (16), if the Insured, on the basis of paid contributions for compulsory health insurance (certified health insurance cards), is entitled to reimbursement for incurred medical expenses from the mandatory health insurance, i.e. the Insurer shall be required to indemnify only part of the medical expenses which are to be borne entirely by the Insured.

(5) If the Insured has concluded insurance for the medical expenses, according to many insurance contracts, the right to reimbursement for medical expenses incurred as a result of the same accident, can be exercised only once, up to the amount of the agreed sum insured.

(6) The insurance contract shall be annulled if, at the time of its conclusion, the insured event occurred or it was about to occur or it was certain that it will occur or if the possibility for its occurrence already ceased at that time, and the Policyholder was familiar with these circumstances or the circumstances could not have been unknown to him.
In this case, the premium paid, reduced for the costs of the Insurer, shall be returned to the Policyholder.

(7) The Insurer shall not be liable to pay the hospital daily benefit in accordance with Article 15, paragraph (15) item 2) hereof if the Insured's stay at a rehabilitation facility is not approved by the treating physician (orthopedist, physiatrist).

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Premium Payment and Consequences of Failure to Pay Premiums

Article 11

(1) Unless it is otherwise agreed, the Policyholder shall be required to pay the total sum of the premium for each insurance year. If it is agreed that the annual premium is paid in semi - annual, quarterly or monthly installments, the Insurer shall be entitled to a premium for the full insurance year.
The insurer shall be entitled to ask for payment of all unpaid premium installments from the current insurance year in the event of any payment from the basis of such insurance.

(2) It shall be considered that the premium is paid on the date when the amount of the payment of the Insurance premium is registered on the Insurer's account.

(3) If the Policyholder has not paid the due premium within the agreed deadline, nor this is done by any other interested party, the insurance contract shall be terminated upon expiration of 30 days since the date when the Policyholder received in hand the registered mail letter from the Insurer, which contains a notification on the maturity of the premium, provided that this period may not expire before the expiration of 30 days of the maturity of the premium.
In any event, the insurance contract shall cease if the premium is not paid within one year of its maturity.

(4) If the insurance is terminated before the agreed deadline, after the payment of the sum insured in case of death or total disability, the premium agreed for the full current insurance year shall belong to the Insurer.

(5) In other cases of termination of the insurance contract before the agreed deadline, the Insurer shall be entitled to the premium only by the date to which the insurance was valid.

(6) The Insurer is entitled to reduce the determined reimbursement of the agreed amount by the amount of an outstanding premium.

Change of Occupation during the Insurance Period

Article 12

(1) The Policyholder, i.e. the Insured shall be obligated to notify the Insurer of the change of his occupation.

(2) If the change of occupation results in change of the risks, the Insurer, in the event of increased risks, shall propose increase of the premium and, in the event of decreased risks, the Insurer shall propose decrease of the premium or increase of the sums insured.
Sums insured and premiums determined in this manner shall be valid from the date of the change of the occupation.

(3) If the Policyholder fails to notify on the change of his occupation, or if the Policyholder does not accept increase or decrease of the premiums within fourteen days, and the insured event occurs, the sums insured shall be reduced or increased in proportion to the premiums paid and the premiums that were to be paid.

Reporting the Accident

Article 13

(1) If the insured event occurs, the insurance beneficiary shall be required to file to the Insurer a claim and policy, i.e. an evidence of his/her capacity as the Insured or insurance beneficiary, as well as additional documentation, depending on the type of insured event, which occurred, in accordance with paragraph (2), (3), (4), (5) and (6) of this Article.

(2) In case of death of the Insured as a result of an accident, the insurance beneficiary shall be required to submit to the Insurer:
   a) Death certificate;
   b) Evidence that the death occurred as a result of an accident: official police report on the occurrence and the type of accident, information and data particularly about the place and the time when the accident occurred, complete description of the event, name and report of the doctor who established that death occurred (the so-called acknowledgment of death), autopsy report (if autopsy was performed) etc.;
   c) Other documents necessary for the Insurer to process the claim for indemnification and to determine the rights of the Insurance beneficiary;
   d) Evidence that the person is entitled to receive the sums insured (final probate decision) – if the insurance beneficiary is not expressly designated for this in the insurance contract.

(3) The Insured who is injured as a result of an accident shall be required to:
   a) See a doctor as soon as possible, i.e. to call a doctor in order to be examined and provided with the necessary attention, and to immediately take all necessary measures for treatment, as well as to comply with the medical advice and instructions regarding the manner of treatment;
   b) Notify the Insurer on the accident in the shortest period of time possible, as soon as his medical condition permits this;
   c) Provide the Insurer with all necessary information and data, particularly about the place and time of the accident, complete description of the event (evidence of the event – reports of injuries at work, police reports etc.), the name of the doctor who examined him or his family doctor, findings of the doctor on the type of physical injury and of any possible consequences, to provide the Insurer with a complete medical record from the first treatment he undergo to the final treatment, as well as information about the physical defects, deficiencies and diseases that the Insured may had even prior to the accident.

(4) In case of disability, the Insured shall also be required to submit to the Insurer medical records – evidence on the established consequences for the purpose of determining the final percentage of permanent disability.

(5) If temporary inability to work with payment of daily benefits for each day of the temporary inability to work is

agreed, and if the temporary inability to work occurs as a result of an accident, the Insured shall be required to submit along with the application the following documentation:

a) Medical records regarding the received first aid, as well as other medical records that would indicate the need for sick leave;
b) Report on the duration of the temporary inability to work issued by the doctor who treated him. This report must contain the doctor's findings with complete diagnosis, accurate information about the time when the treatment started and the period when the Insured was unable to perform his regular occupational activities. For those Insured who are not employed, the duration of the temporary inability to work shall be determined by the Insurer's doctor – censor, on the basis of medical records;
c) Copy of the report of the injury at work (if the injury occurred while performing the occupational activities at work).

(6) If temporary inability to work with payment of daily benefits for previously determined number of days necessary for treatment is agreed, and if the temporary inability to work occurs as a result of an accident, the Insured shall be required to submit the following documentation:
a) Complete medical records regarding the received first aid,
b) Medical records including full diagnosis.
c) Copy of the report of the injury at work (if the injury occurred while performing the activities at work).

(7) If the Insured is facing health problems which have occurred as a result of the accident which require medical attention and thus medical expenses were incurred which are to be borne by the Insured, in accordance with these General Terms and Conditions, the Insured shall be required to submit to the Insurer the original bill that relates to those medical expenses which were incurred due to the accident, as well as an evidence that the medical expenses are already paid (fiscal receipt).

(8) If, due to an accident, the patient's health impaired and he or she requires medical attention in an inpatient facility, the Insured is required to submit to the Insurer the discharge papers from the health care facility where he or she was treated. If the Insurer spent time at an inpatient facility for rehabilitation, he or she must submit to the Insurer also the medical referral or recommendation from the treating physician (orthopedist, physiatrist) stating that the rehabilitation is required.

(9) The expenses for medical examination and doctor's report, (additional medical examinations and specialists' findings) and other expenses related to the determination of the accident and the rights deriving from the insurance contract shall be borne by the claim applicant.

(10) The Insurer shall be entitled to ask for additional explanations from the Insured, the Policyholder, the insurance beneficiary or any other legal entity or individual, as well as to take measures at his own expense for the purpose of medical examination of the Insured by a doctor, medical committees and medical institutions, in order to identify the relevant circumstances related to the reported accident.

(11) The Insurer shall be entitled to ask from the Insured, the Policyholder and the Insurance beneficiary to be provided with all the necessary medical records related to the occurrence of the accident, including the results of the examinations, specialists' findings and copies of the medical records, i.e. to ensure consent of these persons for collecting these data from any other legal entity or individual.

(12) At the request of the Insurer, the Policyholder shall be required to enable access to the Insurer to all records kept by the Policyholder, including a list of insured persons covered by the insurance related to the consequences resulting from the accident (and its submission), for the purpose of determining the relevant circumstances in connection with the insured event. All personal data of the insured persons which are relevant for the conclusion and fulfillment of the Collective insurance contract shall be provided – submitted by the Policyholder to the Insurer with prior fulfillment of all requirements specified by the law regulating personal data protection.

Determining the Insurer's Liability

Article 14

(1) The final percentage of disability shall be determined by the Insurer, according to the Table of disability which is defined and specified in the insurance policy/insurance contract, depending on the type of coverage agreed in the insurance policy, or in the insurance contract.
Individual ability, social status or occupation (professional capability) of the Insured shall not be taken into consideration when determining the percentage of disability.

(2) With reference to multiple injuries caused to particular limbs, spine or organs, the total disability of that particular limb or organ shall be determined in a manner that as maximum disability is considered the percentage provided for in the table of disability, from the next maximum disability half of the percentage of disability is taken as provided for in the Table of disability, and so on and so forth 1/4, 1/8, etc. The total percentage may not exceed the percentage determined in the Table of disability for complete loss of limb or organ. The consequences of a finger injury shall be calculated without using the above mentioned principle.

(3) In the event of loss of several limbs or organs as a result of an accident, the percentages of disability for every limb or organ shall be calculated.

(4) If the sum of percentages of disability according to the table of disability, due to the loss or damage of several limbs and organs as a result of an accident exceeds 100%, the payment may not exceed the sum insured which was agreed in case of total disability.

(5) If the general capability to work of the Insured has been permanently impaired before the occurrence of an accident, the Insurer's liability shall be determined on the basis of the new disability, independently of the previous disability, except for the following cases:

1) if the reported accident caused increase of the previous disability, the Insurer's liability shall be determined on the basis of the difference between the total percentage of disability and the previous percentage;
2) if the Insured, when the accident occurred, lost or injured one of the previously injured limbs or organs, the Insurer's liability shall be determined only on the basis of the increased disability.

(6) If temporary inability to work with payment of daily benefits for previously determined number of days necessary for treatment is agreed, the number of days for which daily benefits are paid shall be determined solely on the basis of the Table of daily benefits, which is an integral part of the insurance contract.

(7) In accordance with the preceding paragraph of this Article, the Insurer shall approve only those consequences of the accident that are listed in the Table of daily benefits.

Payment of the Sum Insured or a Part of the Sum Insured

Article 15

(1) The Insurer shall pay the sum insured or a reimbursement to the insurance beneficiary within 14 (fourteen) days, as soon as the Insurer's liability and the amount of the liability are determined.

(2) If the reimbursement payment is made by mail or bank, it shall be considered that the reimbursement is made at 24.00 hours on the day when the payment in the post office or in the bank is confirmed.

(3) The Insurer shall be required to pay the agreed sum insured, i.e. the reimbursement, only if the accident occurred within the duration of the insurance period and if the consequences resulting from the accident provided for in Article 8 of these General Terms and Conditions occurred within a year from the date of the accident.

(4) The percentage of disability shall be determined in accordance with the table of disability, which is an integral part of the insurance contract, after the treatment is finished, at a time when the condition of the Insured is established as stabilized with reference to the damage suffered and its consequences, i.e. when, according to the doctor's prediction, it cannot be expected that the condition would get better or worse. If such a condition is not established even after the expiration of three years from the date of the accident, the condition established after this period shall be considered final, and according to this condition, the percentage of disability shall be determined.

(5) If certain period of time is necessary in order to determine the amount of the Insurer's liability, the Insurer shall be required, at the request of the Insured, to pay the amount which undoubtedly corresponds to the percentage of disability, which even at that time can be determined, on the basis of the medical records, as permanent disability, but up to 50% of the agreed sum insured. The Insurer shall not be required to pay the advance payment before his liability is determined, taking into consideration the circumstances of the accident.

(6) If the Insured has died before the expiration of one year from the date of the accident, as a result of an accident, and the final percentage of disability has already been determined, the Insurer shall pay the amount agreed upon in case of death, i.e. the difference between the sum insured in case of death and the amount that was paid before for the disability, if such a difference exists.

(7) If the final percentage of disability has not been determined, and the Insured has died as a result of the same accident, the Insurer shall pay the agreed sum insured in case of death, i.e. only the difference between that amount and the possibly paid undisputed part (advance payment), but only if the Insured has died at latest within three years from the date of the accident.

(8) If prior to the determined percentage of disability within three years from the occurrence of the accident the Insured has died out of any reason other than the ones determined in the preceding paragraph of this Article, the amount of Insurer's liability on the basis of disability shall be determined on the basis of the existing medical records.

(9) If temporary inability to work with payment of daily benefits for each day of the temporary inability to work is agreed and if the accident results in temporary inability to work of the Insured, the Insurer shall pay to the insurance beneficiary the agreed amount of daily benefit for all days of the temporary inability to work, in accordance with the doctor's report about the duration of the temporary inability for work. In the event of extended temporary inability to work due to any health reasons, the Insurer shall be required to pay a daily benefit only for the duration of the temporary inability to work caused solely by the accident.

(10) In compliance with the preceding paragraph of this Article, the right to a daily benefit shall be terminated on the day when the Insured has started working, either full-time or part-time.

(11) If temporary inability to work with payment of daily benefits for previously determined number of days necessary for the treatment is agreed, depending on the consequences that occurred as a result of the accident, the Insurer shall pay a daily benefit for the number of days necessary for the treatment of the specific consequences which are listed in the Table of daily benefits, regardless of the actual duration of the treatment of the consequences that occurred as a result of the accident, i.e. the actual duration of the temporary inability to work.

(12) In compliance with the preceding paragraph of this Article, if as a result of the accident the Insured has been established with two or more consequences provided for in the Table of daily benefits, the Insurer shall be required to pay benefit only for that consequence for which the greatest number of days necessary for treatment is foreseen in the Table.

(13) In accordance with paragraph (11) and (12) of this Article, the Insurer shall be held liable only if an accident consequence occurs that is listed in the Table of daily benefits.

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(14) In any case, regardless of the agreed manner of payment of the daily benefits in the event of temporary inability to work, the Insurer's liability shall be limited to a maximum of 200 (two hundred) days for the payment of the daily benefits within 1 (one) insurance year. If an insurance period of less than 1 (one) year is agreed, the maximum liability of the Insurer, which refers to the number of days for which benefit is paid daily, shall be decreased in proportion between the total agreed number of days of insurance and 365 (three hundred and sixty-five), in which case, the maximum number of days for which daily benefit is paid shall be designated in the insurance contract.

(15) If the accident has resulted in impairment of the health condition of the Insured which requires medical attention, and if reimbursement of the medical expenses is agreed, as well as hospital daily benefit, after the treatment, the Insurer shall pay for the following benefits:
    1) Reimbursement of actual and necessary medical expenses, incurred at latest within 1 (one) year from the date of the accident, and
    2) Agreed amount of compensation for each day spent in an inpatient facility within 1 (one) year from the moment of the accident, but for no more than 30 (thirty) days.
    The amount of the daily benefit is specified in the policy, i.e. the insurance contract. In case of occurrence of an accident resulting in health impairment which requires medical attention total liability of the Insurer shall be to pay the medical expenses and hospital daily benefits, and it may not exceed the agreed sum insured for medical expenses.

(16) The medical expenses, as defined in paragraph (15), item 1) of this Article, shall be considered actual and necessary medical expenses for treating the consequences resulting from the accident, in the appropriate health care facilities, except in health care facilities which are in private ownership, which is assessed by the doctor as necessary, and the expenses of which are to be borne by the Insured (participation of hospital attention and treatment, surgical procedures, etc.).

(17) If death or disability of the Insured occurs as a consequence of the accident, the Insurer shall pay the sum insured provided for such cases to the insurance beneficiary, i.e. the Insured, regardless of the daily benefit paid for the temporary inability to work and the reimbursement paid for medical expenses.

Naming the Insurance Beneficiary

Article 16

(1) The beneficiary in case of death of the Insured shall be specified in the insurance policy, i.e. in a separate statement which is an integral part of the insurance policy.

(2) If it is not particularly determined in the insurance policy or in the additional terms and conditions to these General Terms and Conditions, insurance beneficiaries in case of death of the Insured shall be the legal heirs of the Insured.

(3) In the event of a disability and/or temporary inability to work, reimbursement of the medical expenses and hospital daily benefits, insurance beneficiary shall be the Insured himself.

(4) In the event of death of the Insured before the payment for the reimbursement for disability, temporary inability to work, medical expenses, i.e. hospital days or other agreed cases, the payment shall be made to the Insurance beneficiary designated for the event of death.

(5) If the insurance beneficiary is a minor, the payment of the sum insured, i.e. the reimbursement shall be made to the parents or guardians.

Procedure of Providing Expert Opinion

Article 17

(1) In the event the Insurer and the Insured or the Policyholder or the insurance beneficiary do not agree concerning the type and the extent of the consequences resulting from the accident or as to whether and to what extent the injury of the Insured as related to the accident, the determination of these facts may be entrusted to two experts - doctors, one of them shall be appointed by the Insurer and the other by the opposite party. Before the expert opinion is given, these two experts shall select a third expert, who shall give his expert opinion exclusively on issues that are contentious among the experts and to the extent of their evaluation.

(2) Each contracting party shall pay the costs of experts appointed by the respective party, while the costs of the third expert shall be paid by the two contracting parties equally.

Cancellation of the Insurance Contract

Article 18

(1) Each contracting party may cancel the insurance contract with indefinite duration, if the contract is not terminated on other grounds. The cancellation shall be made in writing, no later than three months before the expiration of the current insurance year.

(2) If the insurance is concluded for a period longer than five years, each contracting party may, after the expiry of this period, with a six months cancellation notice, notify the other contracting party in writing, on the termination of the contract.

Statute of Limitations

Article 19

(1) The claims arising from the accident insurance contract are subject to limitation under the Law of Contract and Torts.

Final Provisions

Article 20

(1) On the basis of these General Terms and Conditions, and depending on the type of agreed coverage, the Table for determining the percentage of permanent loss of general work capability (disability) of the Insured as a result of an accident shall be an integral part of the accident insurance contract.

(2) On the basis of these General Terms and Conditions, if temporary inability to work with payment of daily benefits for previously determined number of days necessary for treatment is agreed, an integral part of the insurance contract of persons as a result of an accident shall be the Table for determining the number of days necessary for treatment of the consequences resulting from an accident.

Date of implementation: March 11, 2013