Voluntary Health Insurance General Terms and Conditions

I OPENING PROVISIONS

Article 1

(1) These Voluntary Health Insurance General Terms and Conditions (hereinafter: the General Terms and Conditions) shall be an integral part of the Voluntary Health Insurance Contract (hereinafter: the Insurance Contract) concluded on a voluntary basis between the Policyholder and the Insurance Provider, the Joint Stock Insurance Company GENERALI OSIGURANJE SRBIJA Belgrade, which shall be entitled to organize and implement the voluntary health insurance provisions (hereinafter: the Insurer).

(2) The General Terms and Conditions shall define the rights and liabilities of the Policyholder, the Insured and the Insurer, depending on the type of Voluntary Health Insurance Contract concluded.

II DEFINITIONS

Article 2

(1) Certain terms in these General Terms and Conditions shall have the following meaning:

1) **Insured** – a natural person who has concluded an Insurance Contract, or on whose behalf, based on his/her consent, except in case of a group insurance, an Insurance Contract has been concluded with the Insurer, and who, in case of an insured event, shall exercise the rights stipulated in the Insurance Contract;
2) **Family Members** – the spouse or extramarital partner and children of the Insured, only if they are listed in the Insurance Policy and if a premium is paid for them. Children hereof shall mean the children born in a wedlock or out of a wedlock, adopted children, fostered children and children taken care of by the age of 18, or by the age of 26, in case they are full-time students;
3) **Insured person – Insured** (i.e. the Insurance Holder) and family members of the Insured;
4) **Person with National (Compulsory) Health Insurance Plan** (hereinafter: the person with national health insurance) – the Insured Person or a family member of the Insured who is entitled the rights deriving from the national health insurance in accordance with the Law on Health Insurance of the Republic of Serbia and the regulations adopted for the purpose of implementing this Law;
5) **Voluntary Health Insurance Policyholder** (hereinafter: the Policyholder) a legal person, natural person, other legal entity or a related legal person thereof, who, on the behalf of and at the expense of the Insured Person, i.e. on his personal behalf and at the expense of the Insured, concludes an Insurance Contract with the Insurer and is committed to pay the premiums from his personal funds or from the funds of the Insured; the Policyholder and the Insured may be one and the same person;
6) **Applicant** – a natural or legal person who files an application for concluding Insurance Contract with the Insurer;
7) **Application** – a written offer by the Policyholder for concluding Insurance

Contract with the Insurer;

8) **Insurance Policy** (hereinafter: the Policy) – a document certifying the conclusion of the Insurance Contract with the Insurer;
9) **Voluntary Health Insurance Document** – a document issued to the Insured Person by the Insurer, based on which the Insured can prove the status of an insured person under the Voluntary Health Insurance and can exercise the rights deriving from the respective Insurance Contract;
10) **Insurance Premium** (hereinafter: the Premium) – the amount of money that the Policyholder is obliged to pay, based on the Insurance Contract;
11) **Compensation for Medical Expenses** – the amount of money the Insurer is obliged to pay under the Insurance Contract in case of an insured event, being the expense of the Insured Person for all reasonable healthcare service rendered (medically justified treatment), which, in certain cases, is defined in the Insurance Policy and in the Special Insurance Terms and Conditions;
12) **Indemnity** – the compensation which the Insurer is obliged to pay to the Insured in case of loss of earnings or salaries or other income due to temporary work incapability, compensation for transportation costs relating to the provision of healthcare services, as well as other indemnities related to the exercise of the rights deriving from the Voluntary Health Insurance, as defined in the Insurance Contract;
13) **Sum Insured** - the maximum agreed amount of liability of the Insurer, as specified in the Insurance Policy;
14) **Insured Event** - any future, uncertain, independent of the will of the Policyholder, i.e. Insured, occurrence which implies and activates the obligations of the Insurer.
15) **Group Insurance** – the voluntary health insurance that the Policyholder concludes with the Insurer he has chosen in accordance with the law, for which the Policyholder and the Insurer conclude an Insurance Contract;
16) **Healthcare Services** – the services provided in medical institutions and other forms of healthcare facilities (hereinafter: the private practice), in accordance with the law which regulates the healthcare, aimed at providing healthcare protection, i.e. for the implementation of measures for preservation and improvement of people's health, prevention, suppression and early detection of illnesses, injuries and other health impairments, treatment and rehabilitation, including traditional medicine healthcare services which are safe, quality and efficient;
17) **Medical Institution** – a legal entity that performs healthcare activities, which has been granted a license by the competent Ministry of Health (hereinafter: the Ministry), to perform healthcare activities in accordance with the law which regulates the healthcare protection, as well as with the regulations adopted for the purpose of implementing that law;
18) **Private Practice** – a different healthcare facility where particular healthcare activities are performed, which has been granted a license by the Ministry to perform certain healthcare activities in accordance with the law which regulates the healthcare protection, as well as with the regulations adopted for the purpose of implementing that law;
19) **Other Healthcare Service Providers** – other legal entities or natural

persons that perform certain activities related to healthcare, i.e. provide medical – technical aids, which have been granted a license by the competent authority to perform such activities in accordance with the law;

20) **Healthcare Service Providers** – a common name for the medical institution, private practice and other healthcare service providers;
21) **Healthcare Service Provider Network** – all providers of healthcare services that have concluded effective Contract to render services with the Insurer during the validity period of the concluded Insurance Contract, in which the Insured Person may use the services agreed in the Insurance Policy, in a manner defined in the General and Special Terms and Conditions;
22) **Medicine** – a product containing a substance or a combination of substances manufactured and intended for treatment or prevention of illnesses in humans, diagnosis, improvement or change of the physiological functions, aimed at achieving other legitimate medical purposes, that has been granted a marketing license in the Republic of Serbia, as well as a product that has not been granted a marketing license in the Republic of Serbia and is imported based on the authorization of the Medicines and Medical Devices Agency of the Republic of Serbia, in accordance with the laws regulating the field of medicine;
23) **Medical-technical aids** – all medical devices used for functional and aesthetic replacement of lost body parts, i.e. devices that provide support, prevent occurrence of deformities and correct existing deformities and facilitate basic vital functions;
24) **Implants** – the medical devices that are surgically built in the human body;
25) **Waiting period** (**benefit qualifying period)** – an agreed period at the commencement of the contracted insurance period, during which the Policyholder is obliged to pay the premium, and during which period there is no liability for the Insurer to indemnify the expenses in case of occurrence of an insured event, as defined in the Special Terms and Conditions;
26) **Insurer's Special Terms and Conditions** – the Insurer's terms and conditions which regulate the rights and liabilities of the contracting parties for a specific type or a combination of types of voluntary health insurance, which are an integral part of the Insurance Contract (hereinafter: the Special Terms and Conditions).
27) **Medical Call Center** – the Insurer's telephone service that operates 24/7, 365 days a year, with medically trained personnel available to the Insured Persons, aimed at providing assistance and activation of the insurance services, as specified in the Special Terms and Conditions.

III GENERAL PROVISIONS

Article 3

(1) The Policyholder shall be obliged under the Insurance Contract to pay a premium to the Insurer, while the Insurer shall undertake, in case of an insured event, to indemnify the medical treatment expenses or to pay the indemnity in accordance with these General Terms and Conditions, the Special Terms and Conditions and the Insurance Contract.

(2) All notices and applications the contracting parties are obliged to submit, must be confirmed in writing or by an e-mail, if the same are made orally, by telephone or otherwise.

(3) The date of receipt of the notice, i.e. the application, referred to in paragraph (2) of this Article shall be considered the day when the Insurer received the notice or the application, or the date written on the Insurer's register protocol and the seal or stamp put on the received notice, i.e. application.

(4) All arrangements relating to the content of the Insurance Contract shall be considered valid only if concluded in writing.

(5) Every conversation between the Insured Person and the medically trained personnel in the Medical Call Center shall be recorded.

Eligibility

Article 4

(1) The status of Insured Person with a parallel and additional health insurance with the Insurer can be granted to a person who has a national health insurance, which is proved with a document issued by the Public Health Institute of the Republic of Serbia, who expresses a clear intention to conclude an Insurance Contract with the Insurer, in accordance with the General and Special Terms and Conditions of the Insurer for a type of parallel, i.e. additional health insurance.

(2) The status of Insured Person with a private health insurance can be granted to a person who does not have national health insurance, but expresses a clear intention to conclude an Insurance Contract with the Insurer, in accordance with the General and Special Terms and Conditions of the Insurer for a type of private health insurance.

(3) The status of Insured Person with a voluntary health insurance in case of using health care services by the Insured Person during his stay abroad, can be granted to a person who has a national health insurance, or can be granted to a person who does not have a national health insurance, but expresses a clear intention to conclude an Insurance Contract with the Insurer, in accordance with the General and Special Terms and Conditions of the Insurer for a type of voluntary health insurance in case of using health care services by the Insured person during his stay abroad.

Entering into an Insurance Contract

Article 5

(1) The Insurance Contract shall be concluded based on a previous written application for conclusion of an Insurance Contract, submitted by the applicant on an Insurer's form.

(2) In case of concluding a Group Insurance Contract, the Policyholder may submit a single application containing data on each and every person for whom the Insurance Contract shall be concluded with the Insurer.

(3) When concluding an Insurance Contract, the Policyholder, i.e. the Insured Person, shall be obliged to inform the Insurer on all circumstances that are important for risk assessment, and of which the Insurer is or must have been familiar with.

(4) When concluding an Insurance Contract, upon a request of the Insurer, the Insured Person shall be obliged to fill in a Statement on the Insured Person's Health Condition in the form of a questionnaire (hereinafter: the Statement), which shall be an integral part of the application, to undergo a medical examination and submit other documentation for the purpose of determining a possible risk.

(5) The data written in the Statement cannot be the reason for denial of the Voluntary Health Insurance.

(6) The written application must contain accurate, correct and complete data which is relevant and necessary for concluding an Insurance Contract, as well as those facts that are important for taking a possible risk.

(7) The written application submitted to the Insurer for conclusion of an Insurance Contract shall be binding upon the applicant for a period of 8 (eight) days as of the day when the application was submitted to the Insurer, if the applicant has not specified a shorter period, and in case a medical examination is needed it shall be binding for a period of 30 (thirty) days.

(8) The application shall be considered delivered to the Insurer on the day when it is officially registered by the Insurer. In case the Insurer, after receiving the application by the Policyholder, requests additional data or documentation, the application shall be considered delivered to the Insurer on the day when the Insurer receives the requested data or reports pertaining to the medical examination done.

(9) If the Insurer, within 8 days, or 30 days if medical examination is needed, as of the day when the application was submitted to the Insurer, fails to offer modified insurance conditions, it shall be considered that he has accepted the application and that the Insurance Contract has been concluded on the day when the Insurer received the application.

(10) Should the Insurer accept the insurance application only under modified insurance conditions, the Insurance Contract shall be considered concluded on the day when the applicant agreed to the modified conditions.

(11) It shall be considered that the applicant waived the application if he does not agree to the modified insurance conditions within 8 days from the date he received the notification of the Insurer by registered mail, or if he fails to submit the results of the medical examination within 30 days from the date he received the Insurer's written request to undergo a medical examination.

(12) If in the period from the application submission to the insurance contract conclusion, there is an increase of health risks to the Insured Persons, the Insured Person, i.e. the applicant, shall be obliged to inform the Insurer immediately upon finding out about those facts. Increased health risks to the Insured Persons shall be considered all diseases and illnesses, change of occupation, injuries of the Insured

Person, sports or travels to crisis areas, tropical regions or expeditions, as well as other changes that increase the health risks to the Insured Person.

(13) If during an annual physical exam or another examination, in case the services covered by the Insurance Contract are used, it is determined that the Insured Person suffered from a particular illness at the time of conclusion of the Insurance Contract, which was not reported by him during the application submission, the Insurer shall be entitled to offer an insurance contract with modified terms and conditions.

(14) If the applicant does not accept the modified insurance terms and conditions referred to in paragraph (13) of this Article, within 8 days from the date he received the registered letter and the application with modified insurance terms and conditions of the Insurer, the Insurance Contract, upon expiry of this deadline, shall be considered terminated.

(15) In case of termination of the Insurance Contract referred to in paragraph (14) of this Article, the Insurer shall be entitled to the entire amount of the due premium.

(16) By signing the application, i.e. the Insurance Policy, the Insured Person, i.e. the Policyholder, shall confirm the acceptance of the General and Special Terms and Conditions.

(17) All documents submitted to the Insurer by the applicant shall be considered an integral part of the application until the Insurance Policy is issued.

(18) If the Policyholder and the Insured is not the same person, a written consent of the Insured Person shall be requested for the conclusion of a Voluntary Health Insurance, except in case of concluding a Group Insurance Contract.

(19) The application shall be an integral part of the Insurance Contract.

Policy and Document

Article 6

(1) The Insurer shall issue an Insurance Policy to the Policyholder on the day of signing the Insurance Contract.

(2) The Insurer shall issue an Insurance Policy to the Policyholder based on the data written in the application.

(3) The Insurer shall be obliged to issue a Voluntary Health Insurance Document to the Insured Person (hereinafter: Document), based on which the rights deriving from the Voluntary Health Insurance can be exercised, on the date when the Policy was issued and no later than 60 days thereafter.

(4) The rights deriving from the Voluntary Health Insurance shall be exercised based on this Document, and, in exceptional cases, based on the Policy by the time of obtaining the Document. In case the Document is lost, the rights deriving from the insurance shall be exercised based on a certificate, i.e. a Policy, until a duplicate of the Document is issued.

(5) As regards the Insurance Contracts that are concluded for a period of 90 days or less, the Insured Person shall exercise his rights deriving from the Voluntary Health Insurance solely based on the Insurance Policy.

Types of Voluntary Health Insurance and Risks Covered under the Insurance Contract

Article 7

(1) The Voluntary Health Insurance shall cover expenses for the type, content, scope and standard of rights which are contracted with the Insurer, i.e. for the indemnities specified in the Insurance Contract.

(2) The Voluntary Health Insurance shall be concluded on a voluntary basis and can be concluded as:

1) Parallel Health Insurance that shall cover the medical expenses incurred when the Insured is a beneficiary of a national health insurance in a manner and procedure other than the manner and procedure of exercising the rights deriving from the national health insurance prescribed by the law that regulates the health insurance and the regulations adopted for the purpose of implementing this Law.
2) Additional Health Insurance that shall cover the expenses for healthcare services, medicines, medical-technical aids and implants, i.e. for indemnities not covered under national health insurance i.e. for insurance of greater content, scope and standard of rights, and the amount of indemnities covered under the national health insurance;
3) Private Health Insurance that shall imply insurance of persons not covered under the national health insurance or not included into the national health insurance, for the coverage of the expenses for the type, content, scope and standard of rights contracted with the Company.
4) Voluntary Health Insurance in case of using healthcare services by the Insured during his stay abroad, that shall cover the medical expenses incurred when the Insured is a beneficiary of a national health insurance in a manner and procedure other than the manner and procedure of exercising the rights deriving from the national health insurance prescribed by the law that regulates the health insurance and the regulations adopted for the purpose of implementing this Law, i.e. shall cover the expenses for healthcare services, medicines, medical-technical aids, i.e. for indemnities not covered under the national health insurance i.e. for the insurance of greater content, scope and standard of rights, and the amount of indemnities covered under the national health insurance, i.e. for the insurance of persons not covered under the national health insurance or not included into the national health insurance, for the coverage of the expenses for the type, content, scope and standard of rights contracted with the Company;
5) a combination of Parallel, Additional or Private Health Insurance.

Duration of the Insurance Contract

Article 8

(1) The types of Voluntary Health Insurance referred to in Article 7 paragraph (2) items 1) and 2) shall be concluded as long-term insurance contracts, for a period not

shorter than 12 months from the insurance commencement date, except when the status of the Insured Person under the national health insurance lasts for a shorter period, in accordance with the regulations deriving from the national health insurance, and the Policyholder shall be obliged to notify the Insurer of the termination of his status of insured person.

(2) The types of Voluntary Health Insurance referred to in Article 7 paragraph (2) items 3) and 4) shall be concluded as long-term insurance contracts, as well as for a period shorter than 12 months.

(3) The type of Voluntary Health Insurance referred to in Article 7 paragraph (2), item 5) shall be concluded for a period pursuant to paragraph (1) and (2) of this Article, depending on the combination of the insurance types defined in the Insurance Contract.

(4) The Insurance Contract shall come into effect at 24:00 hrs on the date specified in the Insurance Policy as the insurance commencement date (hereinafter: the insurance commencement date), but not before 24:00 hrs on the date of payment of the premium, i.e. an installment of the premium, unless otherwise agreed in the Insurance Policy or in the Special Terms and Conditions.

(5) The Insurance Contract shall terminate at 24:00 hrs on the date specified in the Insurance Policy as termination date of the insurance (hereinafter: the termination date).

Article 9

(1) The Insurance Contract shall terminate before the agreed period in the following cases:

1. In case of a Parallel, Additional and Private, or a combination of Parallel, Additional or Private Health Insurance:
   - Death of the Insured Person – on the date when the death occurred;
   - Exclusion of the Insured Person from the Insurance Contract by the Policyholder in case of a Group Insurance Contract – on the date of submission of the application to the Insurer, only if such right is provided for in the Special Terms and Conditions of the Insurer, or agreed in the Insurance Policy;
   - Termination of the Insurance Contract, in accordance with Article 16 of these General Terms and Conditions;
   - Cancellation of the Insurance Contract – upon the expiration of the notice period, in accordance with Article 17 of these General Terms and Conditions;
2. In case of a Parallel and Additional, or a combination of Parallel and Additional Health Insurance:
   - Loss of status of Insured Person with national health insurance – on the date of loss of the status;
3. In case of a Private Health Insurance:
   - By obtaining the status of Insured Person with national health insurance – on the date of obtaining the status;

Waiting Period (Benefit Qualifying Period)

Article 10

(1) The Insurance Contract may also define the waiting period (hereinafter: the benefit qualifying period).

(2) The waiting period shall be the period from coming into effect of the Insurance Contract as specified in the Insurance Policy, provided that the due agreed premium has been paid by that date.

(3) If the due premium is not paid by the date of coming into effect of the Insurance Contract, the waiting period shall commence at 24:00 hrs on the date when the first agreed premium is paid.

(4) The waiting period shall not apply for Insurance Contract renewal, unless otherwise defined in the Insurance Contract.

(5) The provisions of paragraph (4) of this Article shall apply only to the Insured Persons who have already been granted the status of Insured Persons under the previous Insurance Policy, i.e. the Insurance Contract, i.e. for whom the waiting period has already expired during the previous Insurance Policy. If the waiting period has not fully expired during the previous policy period, the remaining period up to the expiry of the waiting period shall be transferred to the next period of insurance defined in the new Insurance Policy.

(6) For certain insurance coverage items, the Insurer may define other waiting periods, in accordance with the Special Terms and Conditions of the Insurer.

Commencement and Termination of the Insurer's Liability

Article 11

(1) The liability of the Insurer shall commence at 24:00 hrs on the date specified in the Insurance Policy as the insurance commencement date, but not before 24:00 hrs on the date when the premium, or the premium installment is paid, unless otherwise defined in the Special Terms and Conditions.

(2) The liability of the Insurer shall terminate at 24:00 hrs on the date specified in the Insurance Policy as the insurance termination date.

(3) If a waiting period is agreed, the liability of the Insurer shall commence at 24:00 hrs on the date upon the expiry of the waiting period, provided that the premium, i.e. the premium installment, is paid.

Scope of the Insurer's Liability

Article 12

(1) The Insurer shall be obliged to enable the Insured Person under the Voluntary Health Insurance to exercise the rights defined in the Insurance Contract and the rights stipulated in these General Terms and Conditions, in the Special Terms and Conditions and the Insurance Contract.

(2) The Insured Sum specified in the Insurance Policy shall represent the upper limit of the Insurer's liability, based on the Insurance Contract.

(3) In case the Insured Person, i.e. the Policyholder, failed to provide the Insurer with accurate and complete data at the time when the Insurance Contract was concluded, which may affect the amount of the agreed premium, the Insurer's liability shall be reduced in proportion between the premium paid and the premium which should have been paid according to the actual risk, if the insured event occurs as a result of violation of the provisions of Article (5) of these General Terms and Conditions.

Article 13

(1) In accordance with the Insurance Contract or the Insurance Policy, these General Terms and Conditions and the Special Terms and Conditions, the Insurer shall be obliged to compensate the medical expenses or a part thereof to the healthcare providers or to the Insured Person, which have been incurred during the exercise of the rights deriving from the type of agreed Voluntary Health Insurance, as well as the amount of the agreed compensations, within 14 days from the date when he received the evidence and confirmed the existence and scope of his liability.

(2) The Insurer shall be entitled to request from the Insured Person, the Policyholder, or any other legal or natural person further explanation or additional documentation to determine the important circumstances relating to the insured event reported.

(3) The Insurer shall be entitled to ask the Insured Person to undergo a control examination or additional medical examination in order to establish the necessary facts relating to the insured event reported. The expenses for such examinations shall be borne by the Insurer.

(4) If the Insured Person, in an attempt to obtain for himself or for any other legal or natural person illegal material benefit, by false presentation or concealment of facts, misleads or continues to mislead the Insurer and thereby makes him take action or not take action to his personal or to other person's property detriment, the Insurer may file a criminal charge against that Insured Person.

Exclusion of the Insurer's Liability

Article 14

(1) The Insurer's liability shall be waived in the following cases:

1. In case the Insured Person provided inaccurate and false data or concealed important circumstances that affect the conclusion of the Insurance Contract;
2. In case the Policyholder, i.e. the Insured Person or any other person on his behalf who has legal interest the premium to be paid, fails to pay the due premium within the agreed term;
3. In case of misuse of the Policy, i.e. Document;
4. In case the scope of healthcare services agreed and the amount of expenses are exceeded;
5. In case the claim is based on false data and false documentation;
6. In case the insured event occurred and lasted at the time of conclusion of the Insurance Contract, i.e. in case it covers the costs for treatment of illnesses the Insured Person was suffering from at the time of conclusion of the Insurance Contract, unless otherwise agreed;
7. In case the insured event occurred during the insurance period, and the treatment of the Insured Person continued upon the expiry of the Insurance

Contract period, the Insurer shall be obliged to pay for the medical expenses, i.e. to pay the agreed compensation for the expenses incurred by the date of expiry of the Insurance Contract, except in case the Insurance Contract is renewed in accordance with the provisions of Article 18 of these General Terms and Conditions;
8. In case the subject of the claim relates to the costs for organizing and implementing preventive vaccination programs, immune-prophylaxis and chemo-prophylaxis;
9. For compensation of medical expenses and payment of compensation covered by the national health insurance, except in case of private health insurance.

Premium

Article 15
(1) The Insurance Contract, i.e. Insurance Policy, shall also stipulate the insurance premium amount and the premium payment method.

(2) The Policyholder, i.e. the Insured Person, shall be obliged to regularly pay the insurance premium to the Insurer, when due, within the deadlines specified in the Insurance Contract, i.e. the Insurance Policy.

(3) Whether it is agreed that the annual insurance premium be paid in semi-annual, quarterly or monthly installments, the Insurer shall be entitled to the premium for the entire insurance year.

(4) The insurance premium shall be considered paid when it is registered on the current bank account of the Insurer.

(5) The Insurer shall be obliged to accept the insurance premium paid by any third party that holds legal interest to have the insurance premium paid.

(6) The Insurer cannot increase the agreed insurance premium during the period for which the Insurance Contract has been concluded.

(7) As an exception to paragraph (6) of this Article, in case of long-term insurance contracts, the premium may be changed upon a period of 12 months from the date of conclusion of the Insurance Contract, i.e. every 12 months until the expiry of the term for which the Insurance Contract has been concluded.

Consequences in Case of Failure to Pay the Insurance Premiums

Article 16
(1) If the Policyholder fails to pay the stipulated insurance premium, i.e. the premium installment, when due, the Insurer’s liability to cover the expenses, i.e. part of the expenses for providing healthcare services that are included in the Insurance Contract, i.e. Insurance Policy shall cease upon the expiration of 30 days from the day when a written notification on the due and outstanding insurance premiums was received.

(2) Upon the expiration of the period referred to in paragraph (1) of this Article, the Insurer may terminate the Insurance Contract without a subsequent termination notice period, and institute a procedure for collection of due premiums with corresponding default interest before a competent court.

Annulment and Cancellation of the Insurance Contract

Article 17
(1) If the Policyholder, i.e. the Insured Person, intentionally filed inaccurate reports or deliberately concealed some circumstances of such nature that the Insurer would not have concluded an Insurance Contract under the same conditions if he had known the actual situation, the Insurer may request annulment of the Insurance Contract.

(2) The Insurer's right to request annulment of the Insurance Contract shall cease if within 3 days after finding out about the inaccuracy of the application or concealment of facts, it does not notify the Policyholder about his intention to exercise that right.

(3) The Policyholder, i.e. the Insurer, may cancel the Insurance Contract in a manner and within the deadlines stipulated in the Special Terms and Conditions.

Continuation of the Insurance Contract or Insurance Contract Renewal

Article 18
(1) If the Insured Person wishes to renew the Voluntary Health Insurance under different terms and conditions, or the Policyholder is changed, the current Insurance Contract shall cease to be valid and a new one shall be concluded without discontinuation of the insurance.

(2) The Insured Person shall be entitled to a compensation for the medical expenses incurred or to an indemnity in accordance with the terms and conditions of the Insurance Contract which is valid on the date of occurrence of the insured event.

(3) The renewal of the Insurance Contract referred to in paragraph (1) of this Article shall be done on the basis of a written application, no later than 30 days before the date of the new insurance, i.e. before the expiration of the insurance period stipulated in the valid Insurance Contract.

Complaint by the Insured

Article 19
(1) The Insured Person who believes that his rights guaranteed under the Insurance Contract have been violated with the decision of the Insurer based on the claim, may file a complaint to the Complaint Commission within 30 days after receiving the Insurer's decision.

(2) The Complaint Commission shall be obliged to make a decision regarding the complaint within 14 days after receiving the complaint filed by the Insured Person.

Insured Persons' Data

Article 20
(1) By signing the Insurance Policy, the Policyholder and the Insured Person shall authorize the Insurer to collect, verify, process, store, transmit and use all personal data necessary for concluding the Insurance Contract in accordance with the Law on Personal Data Protection.

(2) The Insurer shall undertake to keep the data referred to in paragraph (1) of this Article as a trade secret in accordance with the law.

Applicable Law and Jurisdiction

Article 21
(1) Implementation, effect and interpretation of the Insurance Contracts concluded under these General Terms and Conditions and the Special Terms and Conditions shall be subject to the legislation and court jurisdiction of the Republic of Serbia.

Subrogation

Article 22
(1) The rights of the Policyholder, i.e. the Insured Person pertaining to a third party shall be transferred to the Insurer, in the amount of the liability paid by the Insurer, without special consent by the Insured Person.

(2) For the purpose of exercising the right to receive reimbursement under paragraph (1) of this Article, the Insured Person shall be obliged to provide the Insurer with any evidence requested by the Insurer related to the claim. The expenses of obtaining such evidence shall be borne by the Insurer.

(3) If the Policyholder, i.e. the Insured Person, receives compensation from a third party responsible for the damage, the Insurer shall be entitled to deduct the amount of the compensation he should pay to the Insured Person, based on the Insurance Policy.

IV TRANSITIONAL AND FINAL PROVISIONS

Article 23
(1) These General Terms and Conditions may be amended in accordance with the procedure and the method they were adopted by.

(2) The amended Terms and Conditions shall apply only to the new Insurance Contracts, i.e. Insurance Policies.

(3) Until the expiry of the insurance year, the General Terms and Conditions under which the Insurance Contracts have been concluded shall apply to the valid Insurance Contracts, unless the change of the terms and conditions occurred due to the changes in the legal regulations which cannot be influenced by the Insurer.

(4) If the Insurer introduces any amendments to the General Terms and Conditions, he shall be obliged to inform thereof in writing the Policyholder, i.e. the Insured Person with whom he has concluded a long-term Insurance Contract.

(5) The Insurer is required to post these updated General Terms and Conditions on its web page

Article 24
(1) The receivables deriving from the Insurance Contracts shall expire in accordance with the provisions of the Law on Contracts and Torts.

Article 25
(1) The relations between the contracting parties which are not regulated by these General Terms and Conditions, are subject to the provisions of the Voluntary Health Insurance Regulations, the Law on Contracts and Torts and other regulations of the Republic of Serbia

Article 26
(1) The effective date of these General Terms and Conditions is the date of issue, and the implementation date is January 1st 2010, subject to the opinion of the Ministry of Health.