

SECTION I. DEFINITIONS

Article 1. The terms used in these General Terms and Conditions have the meanings defined below:

- 1. The insurance contract**, referred to as the **Insurance policy** or the „contract“ or the „policy“ is concluded in writing. These General Terms and Conditions, the Special Terms and Conditions of the contract/policy, and the eventual addenda thereto are an integral part of the insurance contract, as well as all notices, declarations and consents signed by the parties to comply with the requirements of the General Data Protection Regulation (Regulation (EU) 2016/679). The Bulgarian is the subsidiary applicable law.
- 2. The Special Terms and Conditions** are a part of the contract containing the specific names, addresses, terms, dates, amounts and conditions, as well as other requisites determined by the Insurance Code.
- 3. Addendum** is an extraordinary part of the contract, which contains amendments or additions to the contract.
- 4. Parties to the contract** are the Insurer and the Policy holder.
- 5. Insurer** is Solely Owned Joint Stock Insurance Company (ZEAD) Bulstrad Life Vienna Insurance Group EAD with headquarters and address of management: Sofia, 6, Sveta Sofia St.
- 6. Policy holder** is the person, which concludes the insurance contract with the Insurer and pays the contractual premium. If the life of the Policy holder is insured, then the Policy holder is also the Insured.
- 7. Insured** is the individual, resident of the European Union or a third country, if residing permanently in an EU member state, on whose life and bodily integrity the insurance is concluded.
- 8. Beneficiary** is the person entitled to receive the insurance amount upon the occurrence of an insurance event. The beneficiary is specified in the insurance contract. Beneficiary may be the Policy holder, or the Insured, or the legal heirs of the Insured, or another person specified by the Policy holder.
- 9. Group of insured persons** are 10 or more persons gathered according to a certain criterion different from their wish to be included in insurance.
- 10. Term of the insurance** is the term, for which the insurance contract is concluded. Its beginning and end are stated in the Special Terms and Conditions or in a subsequent addendum for extension of the insurance period.
- 11. Insurance coverage period** is the period for which the Insurer covers the insurance risks.
- 12. Insurance period** is the period, for which the insurance premium is determined. This term is one year, unless a shorter or longer term is agreed. The insurance period may coincide with the term of the contract. It is also possible that the term of the insurance contract includes more than one insurance period.
- 13. Insurance year** is the part of the insurance period representing the time between the two anniversaries of the contract. The anniversaries are counted from the beginning of the insurance period.
- 14. Waiting period** is the period specified in these General Terms and Conditions from the beginning of the insurance coverage for which the Insurer does not owe payments for occurring insurance events.
- 15. Insurance event** is an event occurring during the insurance period resulting in insurance liability, where such event is due to a risk covered by this insurance.
- 16. Covered risk** is a possible consequence of occurrence of insurance event determined in the terms and conditions of the insurance contract, upon the realization of which the Insurer must pay the insurance amount or a percentage of it. The risks covered by the specific insurance contract are described in the Special Terms and Conditions.
- 17. Insurance amount (liability limit)** is the amount of money agreed by the parties and stated in the insurance contract representing the upper liability limit of the Insurer against the Policy holder, the Insured or the beneficiary.
- 18. Insurance premium**, hereinafter referred to as the „premium“, is the amount which the Insurer demands against the liabilities of the Insurer under the insurance contract.
- 19. Accident** is unforeseen, random and sudden event of origin external to the Insured, occurring during the validity of the insurance coverage, not of the will of the Insured, which event has caused body injury of the Insured (e.g. external or internal injury, broken or cracked bone, joint spraying, tearing or stretching of a tendon or a muscle, burning or frostbite of the body surface, poisoning, suffocation or drowning, etc.).
- 20. Occupational accident** is a sudden health damage occurring during and in relation, or on the occasion of the work, as well as any work done for the benefit of the enterprise, where such damage has caused work incapacity or death.
- 21. Household accident** is any other accident not included in the definition of occupational accident.
- 22. Self-inflicted condition** is an insurance event due to a deliberate harm to the own health committed by the Insured or by any of the beneficiaries, or at their instigation;
- 23. Illness** is a combination of complaints and clinical manifestations diagnosed in a licensed health facility for the first time during the insurance period and registered in an official medical document. As a date of occurrence of the illness, the date of its initial

diagnosing is considered.

- 24. General illness** is any illness according to the criteria of the World Health Organization, which is not defined as an occupational illness or a traumatic injury.
- 25. Occupational illness** is illness, for which a diagnostic medical commission has issued an act for occupational illness.
- 26. Acute illness** is an illness or sickness, which occurs acutely, suddenly and unforeseeably, endangers the life or the health of the Insured, has severe symptoms and short duration, including any intensive symptoms, such as severe pain, and requires urgent medical care.
- 27. Pre-existing illness, damage or condition** is illness, injury, medical condition or symptom:
 - 27.1. for which treatment or medications or consultations, or diagnosis have been sought or have been obtained, or have been expected by the Insured or by the beneficiary before the beginning of the policy for the Insured, or
 - 27.2. whose origin precedes the beginning of the policy or has been known to the Insured before the beginning of the policy, whether or not treatment or medication, or consultations, or diagnosis have been sought or received.
- 28. Chronic illness** is a disease or injury that has one or more of the following characteristics:
 - 28.1. there is no known recognized treatment for it;
 - 28.2. it continues indefinitely;
 - 28.3. it recurs or is likely to recur;
 - 28.4. it is permanent;
 - 28.5. it requires palliative treatment;
 - 28.6. it requires long-term monitoring, consultations, examinations, control examinations or tests;
 - 28.7. the individual fighting it must be rehabilitated or specially trained.
- 29. Congenital diseases** are congenital disorder, physical abnormality, and/or any abnormality that has occurred after birth, or a medical condition acquired during fetal development, whether or not diagnosed at the time. For the insurance purposes, it is irrelevant whether the congenital disease is due to heredity or the environment.
- 30. Infectious disease** is a disease caused by viruses, bacteria, parasites or other organisms that can be transmitted from person to person through direct contact, airborne droplets, surfaces or objects, or by biological vectors (insects or ticks) or animals.
- 31. Epidemic** is the unusually and unexpectedly rapid and wide spreading of a particular disease within a specific geographical area in a relatively short period of time.
- 32. Pandemic** is a type of global epidemic affecting a large region, continent or the whole world and characterized by the emergence of a new virus or infectious carrier against which the human population has no immunity.
- 33. Permanently reduced or lost work ability (disability)** is a definitive and irreversible reduced or lost work ability of the Insured to perform routine activities and occupations due to impaired function of a single organ or the whole organism occurring during the insurance coverage period. The permanently reduced or lost work ability is determined in percentages by the Territorial Expert Medical Commission (TEMC), the National Expert Medical Commission (NEMC), and is confirmed by the trusted doctor of the Insurer or the Insurance Medical Commission (IMC) of the Insurer. As a date of occurrence of the permanently reduced or lost ability, the date of disablement specified in the decision of TEMC/NEMC or IMC is considered.
- 34. Territorial Expert Medical Commission (TEMC)/National Expert Medical Commission (NEMC)** are statutory bodies in Republic of Bulgaria that determine the type, extent, period, date of occurrence and reasons for permanently reduced or lost work ability.
- 35. Insurance Medical Commission (IMC)** is a body of the Insurer determining the type, extent, period, date of occurrence and reasons for permanently reduced or lost ability.
- 36. Temporary work incapacity** is a reduced or totally lost ability to carry out normal activities and occupations as a result of a transient reduction of the general or local functions of the body, recoverable within a certain period during which the Insured actually uses a sick leave starting within the insurance coverage period. The duration of the temporary work incapacity is determined in accordance with the applicable regulations.
- 37. Medical expenses** is a coverage that, if agreed in the insurance contract, includes the expenses for:
 - 37.1. medical examinations, tests, treatment and outpatient surgical intervention;
 - 37.2. medicines, medical devices and consumables;
 - 37.3. hospital treatment, including surgical intervention;
 - 37.4. emergency transportation of the Insured by specialized medical transport from the place of the accident or the place of occurrence of the illness to the nearest medical facility providing emergency and urgent medical care;
 - 37.5. transport of the Insured on hospital treatment to another hospital in the country;
- 38. Unexpected and urgent medical expenses** are medical expenses urgently imposed due to an accident or a sudden onset of an acute illness, which if not incurred would lead to permanent danger to the health of the Insured and/or serious deterioration of body functions and/or other serious consequences concerning the health and life of the Insured. Unexpected and urgent medical expenses are not the expenses for treating

chronic illnesses existing before the beginning of the insurance period, whose symptoms are similar to those of acute illnesses, unless the chronic illness is manifested as a sudden complication that occurs acutely, requires urgent medical intervention, and endangers the life of the Insured.

39. Hospitalization (hospital stay), within the sense of these General Terms and Conditions, is an uninterrupted minimum 24 (twenty-four) hour stay of the Insured in a hospital under physician prescription for performance of emergency test, monitoring or treatment.

40. Daily allowance for hospital stay (hospitalization) is a pre-agreed amount for each day of hospital stay paid by the Insurer to the Insured if the Insured is hospitalized in a medical facility for hospital treatment during the insurance coverage period as a result of a risk covered by the contract conditions.

41. Daily allowance for post-hospital recuperation is a pre-agreed amount for each day of further ambulatory (home) treatment after hospital treatment (hospitalization) in relation with a risk covered by the contract conditions.

42. Surgery and surgical intervention mean manually or operatively – executed procedure(s) required for treatment of an illness or bodily damage, correction of deformations, diagnosis and treatment of illnesses, or alleviation of suffering performed in a hospital or out of hospital by a physician with a legal capacity.

43. Hospital is a medical facility for hospital treatment, established and licensed in accordance with the applicable Bulgarian law, where persons with acute illnesses, traumas, acute chronic illnesses and conditions requiring surgery in clinical conditions are treated in accordance with the medical standards established in the Republic of Bulgaria. Within the sense of this insurance, "hospitals" are not medical facilities for hospital treatment of individuals in need of long-term health recovery and individuals with chronic illnesses requiring care and maintenance of satisfactory physical and mental condition, as well as individuals requiring physical therapy, motor and psychic rehabilitation, balneology, climate- and thalassotherapy, as well as rehabilitation centers and specialized hospitals, clinics, and wards for the treatment of the mentally ill, alcoholics and drug addicts.

44. Fracture is a medical condition of the bones where there is confirmed disruption/damage of the uninterruptedness and/or the integrity of the bone due to an accident. Within the sense of this insurance, fractures are not pathological fractures where a certain illness has altered the bone structure or has weakened the bone.

45. Burn is a tissue damage caused by thermal, chemical or electric agents and leading to burning of bodily surface.

46. Expenses for medical transportation are actually incurred expenses for emergency transportation of the Insured by specialized medical transport on the territory of the Republic of Bulgaria from the place of the accident or the place where an acute illness occurred to the nearest medical facility for emergency medical treatment, as well as expenses for transportation by specialized medical transport for subsequent transfer of the Insured from one medical facility to another where the need for such has been determined by the medical facility conducting the treatment or by the attending physician. A specialized medical transport means an ambulance or another vehicle licensed for medical transportation.

47. Deductible in the incurred medical expenses is the part of the medical expenses covered by the insurance that is paid by the Insured.

48. Terrorism is any act aiming to cause death or to cause serious bodily injury to citizens or civilians in order to intimidate a population or to force a government or international organization to do or to refrain from doing any action.

49. War is invasion, acts of foreign enemies, hostility (whether declared or not), civil war, riots, revolution, revolt, military or usurped power, mutiny, civil unrest and terrorist acts.

50. CYBER event is any unauthorized, incidental or malicious act or series of related unauthorized, incidental or malicious acts, or the threat or fraud involving access to, processing of, use of or operation of any information technology or electronic data by a person or group of persons.

51. Address for correspondence is a postal or e-mail address specified by the Policy holder in the application for insurance or in other documents provided to the Insurer, to which the Insurer sends all messages or notices related to the fulfillment of the contract.

SECTION II. SUBJECT OF THE INSURANCE

Article 2. (1) Subject to these General Terms and Conditions of Risk Life insurance, against paid insurance premium, the Insurer insures one or more individuals hereinafter referred to as the Insured against risks covered according to the terms and conditions of the contract and related to the life, health or bodily integrity of the Insured.

Article 3. (1) Under this insurance, healthy persons are insured. Upon the Insurer's discretion, individuals with additional risk factors may be accepted for insurance under the conditions of aggravated risk.

(2) the aggravated risk under paragraph 1 may be expressed in the individual or combined application of: change of the insurance premium, change of the risk rate, change of the insurance period, exclusion of certain risks, or use of other methods imposed upon the conclusion of the insurance.

(3) Under this insurance, no persons under 14 years old and incapable persons are insured

for the risk of „death“. If, during the insurance contract term the Insured is deemed disabled, the contract is terminated automatically.

(4) The Risk Life insurance cannot be redeemed by the Policy holder.

Article 4. (1) The age of the Insured by the date on entry in force of the contract is between 18 (eighteen) and 70 (seventy) years. The age of the Insured is determined in full years at the beginning of the insurance, while less than six months from the date of birth are not considered and more than six months from it are considered a full year.

(2) By the date of expiration of the insurance, the age of the Insured must not exceed 74 (seventy-four) full years.

(3) Under this insurance, the insurance coverage for Insured persons over the age of 70 (seventy) years is for insurance events only as a result of an accident.

(4) The insurance coverage for the risk of permanently reduced or lost work ability as a result of an illness is offered only to Insured persons whose age by the date of expiration of the insurance period does not exceed 65 (sixty-five) full years.

(5) The insurance coverage for the risk of critical illness is offered only to Insured persons whose age by the date of expiration of the insurance period does not exceed 65 (sixty-five) full years.

Article 5. The Insurer covers the risks underwritten on the territory of the EU member states, unless another territorial scope is explicitly agreed upon.

SECTION III. COVERED AND EXCLUDED RISKS

Article 6. (1) For the purposes of these General Terms and Conditions, the basic covered risks included in the insurance contract scope are:

1. death of the Insured as a result of:

1.1. accident or specific accident; and

1.2. illness or specific illness;

2. permanently reduced or lost work ability of the Insured as a result of:

2.1. accident or specific accident; and/or

2.2. illness or specific illness;

3. temporary work incapacity of the Insured as a result of:

3.1. accident or specific accident;

3.2. illness or specific illness.

(2) The basic risk under paragraph 1, item 1 is mandatory covered by the insurance contract. The risks under paragraph 1, item 2 and item 3 are covered by the insurance contract depending on the wish of the Policy holder.

(3) Upon request by the Policy holder and against payment of an additional insurance premium, additional covered risks may be included in the scope of the insurance contract, such as:

1. daily allowance for hospital stay of the Insured as a result of an accident or a specific accident;

2. daily allowance for hospital stay of the Insured as a result of an illness or a specific illness;

3. daily allowance for post-hospital recuperation of the Insured as a result of an accident or a specific accident;

4. daily allowance for post-hospital recuperation of the Insured as a result of an illness or a specific illness;

5. surgery or surgical intervention as a result of an accident or a specific accident;

6. surgery or surgical intervention as a result of an illness or a specific illness;

7. fractures of the Insured as a result of an accident;

8. burns of the Insured;

9. occurrence of medical expenses or certain medical expenses for the Insured, which is a direct and immediate consequence of the occurrence of an accident or a certain type of accident for the Insured, which is not caused by exclusions from the insurance coverage and is within the limit of the insurance liability;

10. occurrence of medical expenses or certain medical expenses for the Insured, which is a direct and immediate consequence of the occurrence of an illness or a certain type of illness for the Insured, which is not caused by exclusions from the insurance coverage and is within the limit of the insurance liability;

11. critical illnesses.

(3) The risks covered by the specific insurance contract are explicitly described in its Special Terms and Conditions.

(4) For the risks covered under item 2, item 4, and item 4 of paragraph 3, a waiting period of 120 (ninety) days from the date of entry into force of the insurance contract or the individual insurance coverage, as well as from the date of renewal of the insurance contract. The specified waiting period does not apply if the hospitalization or the surgical treatment is due to an infectious disease, as well in care of renewal of the contract without interruption.

(5) For the risk „critical illness“, the General Terms and Conditions of Critical Illness insurance of the Insurer apply.

Article 7. (1) The insurance risks under these General Terms and Conditions, as well as the consequences thereof are not covered in the cases where the insurance event is caused by or is due to:

1. suicide or attempted suicide, self-inflicted condition;
2. committing or attempting to commit a crime of a general nature by the Insured;
3. execution of a death sentence or accident occurring while the Insured is detained by the authorities or is in prison;
4. deliberate acts of the beneficiary resulting in the loss of work capacity or death of the Insured. If there are several beneficiaries, this exception applies only to the actions of the perpetrator;
5. pregnancy, birth, abortion and the resulting complications, unless caused by an accident;
6. treatment of infertility, sterility, as well as treatment through reproductive technologies (intrauterine insemination, in vitro fertilization, ICSI fertilization, etc.);
7. temperature effects – sun or heat strokes, freezing, cold, unless they are the consequence of an accident occurring during the insurance, or unless otherwise agreed;
8. war or military actions (regardless whether the war is announced or not), rebellion, coup d'état state coup, riot, terrorist act, civil unrest or others similar social phenomena directly or indirectly arising from explosion of rockets, bombs, grenades, explosives, including all actions undertaken for prevention or protection against terrorism;
9. nuclear energy, radioactive radiation, nuclear explosions, biological or chemical pollution, natural or ecological disasters and all other similar events with massive consequences. The exclusion for nuclear energy is not applicable where the nuclear energy is used for medical treatment;
- self-treatment, as well as where the Insured has not sought qualified medical help or has refused such, has not followed a medical prescription for test, treatment, consultation, after application of a non-recognized and not-proven treatment, incl. condition after acceptance of medicines that have not been prescribed by a physician with a legal capacity;
10. pre-existing illness, damage or condition;
11. accident suffered by the Insured due to his/her unconscious carelessness (negligence);
12. post-traumatic epilepsy;
13. involvement of the Insured in a bet or challenge, a fight provoked by the Insured or a fight, in which the Insured has participated actively and voluntarily; hooligan actions of the Insured;
14. handling of weapons and explosives;
15. practicing high-risk professions and occupations, including sports and hobbies (such as deemed all kinds of motor, flying, aeronautical, water and underwater sports and activities; jumps from heights; climbing requiring special equipment and speleological activities and winter sports practiced outside the places designated for their practicing);
16. exercising by the Insured of any kind of sports as a professional athlete, including participation in training and sports competitions, unless the insurance contract provides otherwise.
17. manifestation of allergies, side effect of drugs for treatment of damage, occurrence on certain risks related to any medical or surgical procedure, bacterial and viral infections;
18. use of alcohol, narcotics, opiates or stimulants by the Insured;
19. road accidents, regardless whether the Insured was a driver or pedestrian, occurred due to non-compliance with the Road Traffic Act or the Rules on its Implementation, incl. driving a vehicle with speed exceeding the maximum allowed for the respective road section where the road accident has occurred;
20. driving of a motor vehicle by the Insured, where the Insured has no license for the respective motor vehicle category, or where such license has been temporarily revoked;
21. practicing an occupation, for which the Insured there is no valid permit document, if such is required by the law, including driving a land vehicle (except motor vehicles), aircrafts or vessels, without a license or with temporarily revoked license;
22. accident occurred due to non-compliance by the Insured of the occupational safety rules and instructions established by the respective authorities;
23. participation in medical or scientific research, or clinical tests of medical products, as well as experimental treatment;
24. infection with any Human Immunodeficiency Virus (HIV) or if in the body of the Insured there are any HIV antibodies, or if the Insured suffers from the Acquired Immune Deficiency Syndrome (AIDS);
25. psychic illness or behavioral disorders;
26. accident occurred with the Insured during practicing an occupation prohibited by the Labour Code;
27. events occurred when the Insured has violated laws or bylaws in force;
28. epidemics and pandemics;
29. sexually transmitted diseases, as well as gender reassignment and any related complications;
30. dental aid and oral surgery and their complications, unless caused by an accident;
- (2) The Insurer does not make insurance payments for the risk „temporary work incapacity“ if the Insured has not actually used the sick leave days.
- (3) In addition to the exclusions under paragraph 1, the coverage for medical expenses also does not include expenses related to:
 1. examination, treatment and surgery, which have been performed by a non-licensed physician or a non-licensed medical facility;
 2. medical examinations and tests, in which no illness has been diagnosed or an accident

- with the Insured has not been confirmed;
4. rehabilitation, physiotherapy, kinesitherapy;
5. treatment after the repatriation under article 1, item 37, sub-item 37.5, if not explicitly covered;
8. treatment of weight-related problems;
9. plastic or cosmetic surgery intended to correct the appearance, unless it is imposed by disfigurement or acute illness covered by these General Terms and Conditions and the relevant Special Terms and Conditions;
10. examinations, tests and treatment using the methods of non-conventional/alternative medicine;
11. experimental or research services;
12. medical monitoring or research or diagnostic tests, which are part of a routine physical examination or health prophylaxis, including vaccinations, expenses for glasses, contact lenses, hearing aids, certificates, etc.;
13. personal comfort and improved living conditions in hospital treatment, team/physician selection, nursing post, additional support personnel, as well as any administrative and/or user fees, including activities requested and provided (ARP);
14. such portion of the expenses that exceeds the normally necessary and inherent expenses covered under these General Terms and Conditions and the relevant Special Terms and Conditions.
15. genetic research, where molecular-genetic and biochemical-genetic diagnostics is defined as analysis of DNA, RNA, genes, gene products (proteins and enzymes) and specific metabolites for detection of changes related to hereditary or acquired diseases. The analysis is performed through specialized diagnostic genetic tests – cytogenetic and molecular-cytogenetic test, molecular genetic test, biochemical genetic test;
- (4) In addition to the exclusions under paragraph 1, the coverage of this insurance also does not include hospitalization related to:
 1. treatment in an unlicensed medical facility;
 4. conducting rehabilitation, physiotherapy, kinesitherapy, as well as for the purchased medicines, means and use of medical devices in this connection;
 6. aesthetic surgery, unless imposed as a result of a traumatic injury, burn or critical illness occurred during the insurance period.
- (5) This insurance does not cover events resulting directly or indirectly by an infectious disease or threat or fear of infection, including those incurred due to regulatory requirements, measures or orders of the competent authorities, and/or actions or measures of the Insured or third parties for the purpose of or in connection with control and limitation of the spread of the infectious disease, regardless of any other event or circumstance that may be relevant to causing and/or the amount of the damage.
- (6) Notwithstanding the other Terms and Conditions of the insurance contract, this insurance does not cover events resulting directly or indirectly by a CYBER event.
- (7) In the cases listed in the previous paragraphs, the insurance premiums paid are not refunded.
- (8) Upon explicit written agreement between the parties and against payment of an additional premium, certain insurance coverage exclusions may be covered.

SECTION IV. LIMIT OF INSURANCE LIABILITY

Article 8. The due insurance amount in case of occurrence of a risk covered by the policy is specified in the Special Terms and Conditions.

Article 9. The liability of the Insurer to pay the insurance amount arises only if the insurance event has occurred during the insurance period.

Article 10. (1) In case of death of the Insured due to an accident, the Insurer pays the insurance amount only if the death is causally related to the accident and if the death has occurred within 1 (one) year from the date of the accident and if occurred during the individual insurance coverage.

(2) In case of death of the Insured due to an illness, the Insurer pays the insurance amount only if the illness was diagnosed for the first time during the insurance period, the death is causally related to it and if occurred during the individual insurance coverage.

Article 11. (1) The obligation of the Insurer to pay the insurance amount or part thereof in case of permanently reduced or lost work capacity resulting from an illness arises only if the permanently reduced or lost work capacity of the Insured is determined as a disease diagnosed for the first time during the insurance period and the date of disability specified in the TEMC decision is during the individual insurance coverage period.

(2) The liability of the Insurer to pay the insurance amount or a part thereof in case of permanently reduced or lost work capacity has occurred as a result of an accident arises only if the disabilities are causally related to the accident and provided that the permanently reduced or lost work capacity has occurred within 1 (one) year from the date of the accident. Exclusion to the rule in the first sentence applies in cases where the Insured has suffered a temporary loss of work capacity lasting for a period of up to 18 (eighteen) months without interruption, which has immediately passed into a permanently reduced or lost work capacity.

(3) Where the percentage of permanently reduced or lost work capacity is formed by

several illnesses and/or accidents, the Insurer owes payment only if each of them has occurred within the contract period. If the total percentage of permanently reduced or lost ability includes the percentage for illness and/or accident diagnosed or arising before the conclusion of the contract, the percentage for them is excluded from the total percentage.

(4) Permanently reduced or lost work capacity is determined as a percentage in one of the following ways:

1. by the Territorial Expert Medical Commission (TEMC) in accordance with the current regulations;
2. by the Insurance Medical Commission (IMC) of the Insurer according to the Continental Scale representing Appendix No. 1 to these General Terms and Conditions.
- (5) The certification of the permanently reduced or lost work capacity as a result of an accident under the conditions of paragraph 4, item 2 is carried out after the final and complete stabilization of the condition of the Insured but not earlier than three months and not later than one year from the date of the accident. The Insurer is not liable for complications of the condition of the Insured occurring after one year of the date of the accident. Upon demand by the Insured (the Policy holder), in case of limb amputation and eye loss, the percentage of permanently reduced or lost ability is determined without waiting for the expiration of the three-month period, but only upon complete stabilization.

Article 12. (1) In case of a temporary loss of work capacity of the Insured due to an accident or illness, the Insurer pays the insurance amount only if the temporary loss of work capacity has occurred during the insurance period.

(2) In case of a temporary loss of work capacity of the Insured due to an accident, the Insurer pays the insurance amount only if the temporary loss of work capacity has occurred during the individual insurance coverage period, the temporary loss of work capacity is in a causal relationship with the accident and its onset is not later than one month from the date of the accident.

(3) The temporary loss of work capacity is certified by a primary sick leave note and its continuations issued by a licensed medical facility.

(4) The beginning of the primary sick leave note must be after the beginning of the term of the insurance contract and before its expiration. In the series of sick leave notes, there must be only one primary sick leave note, while the others must be its continuation and the diagnoses in them must be the same or in a causal relationship with the diagnosis in the primary sick leave note.

Article 13. (1) The Insurer is liable only for the actual medical expenses, which are up to the amount of the insurance amount specified in the Special Terms and Conditions.

(2) If there are other insurance contracts that provide the Insured similar insurance coverage for medical expenses, the Insured must declare this when submitting the insurance claim. In such cases, the Insurer will be proportionally liable for the incurred expenses, while its share in each expense will be equal to the expenses divided by the number of contracts covering such expenses.

(3) If the Special Terms and Conditions provide for deductible of the Insured in the incurred medical expenses, the Insurer covers the expenses exceeding such deductible.

(4) The insurance covers medical expenses incurred on the territory of the Republic of Bulgaria only if there is temporary work incapacity of the Insured related to the same insurance event, for which the medical expenses were incurred, regardless of whether the insurance contract covers temporary loss of work capacity.

(5) If the insurance within the coverage of the insurance risks covered under the insurance contract covers insurance events occurring with the Insured outside the territory of the Republic of Bulgaria, the Insurer covers only the medical expenses incurred up to 15 (fifteen) days from the date of occurrence of the insurance event and is only liable for unforeseen and urgent medical expenses.

Article 14. (1) In case of death of the Insured, the Insurer pays its legal heirs and the other beneficiaries specified in the insurance contract the insurance amount specified in the insurance contract.

The insurance amount is deducted by the insurance payments made to date for permanently reduced or lost work capacity and/or temporary loss of work capacity and/or medical expenses and/or daily allowance for hospital stay and/or daily allowance for post-hospital recuperation for the same Insured during the validity of the insurance contract.

(2) In case of permanently reduced or lost work capacity of the Insured, the Insurer pays the Insured a percentage of the insurance amount specified in the contract that is equal to the percentage of permanently reduced or lost work capacity determined in the expert decision of TEMC or the IMC of the Insurer (in case of accident). The insurance amount is deducted by the insurance payments made to date for temporary lost work capacity and/or medical expenses and/or daily allowance for hospital stay and/or daily allowance for post-hospital recuperation in relation with the same insurance event. Where the person has already been certified by TEMC as having permanently reduced or lost work capacity due to pre-existing illness, accident or damage that is not due to the claimed insurance event, the Insured is paid the percentage of the insurance amount determined only for damages that are causally related to the illness or accident occurred within the term of the contract. If, before the occurrence of the insurance event, the Insured has had a confirmed in terms of type and extent permanent damage that was additionally damaged by the illness or accident, the insurance amount is deducted by the theoretical compensation for the damage before

the occurrence of the insurance event.

(3) In case of temporarily lost work capacity of the Insured, the Insurer pays the Insured part of the insurance amount specified in the contract, which depends on the duration of the temporary lost work capacity of the Insured.

(4) Where the amount determined for temporary work incapacity exceeds the amount for permanently reduced work capacity, the Insurer pays only the amount for the temporary work incapacity.

(5) The amount for temporary loss of work capacity due to illness may be paid to the Insured no more than once during the term of the insurance contract.

(6) The insurance payments for work incapacity (including both permanent and temporary) payable for a given Insured cannot exceed the insurance amount specified in the Special Terms and Conditions for the same person.

(7) In case of hospitalization of the Insured during the insurance coverage period due to an illness or accident, the Insurer pays the beneficiary for each day of the hospital stay of the Insured the insurance amount specified in the Special Terms and Conditions. The Insurer makes an insurance payment only provided that the hospital stay has lasted more than 24 (twenty-four) hours for a one-time stay up to 20 (twenty) days and no more than 30 (thirty) days in total within the period of the individual insurance coverage.

(8) In case of hospitalization of the Insured lasting more than 24 (twenty-four) hours in connection with an accident or illness, if such is covered under the terms of the insurance contract and in case of need to continue the treatment at home according to the epicrisis issued upon discharge and the sick leave note, the Insurer pays the Insured for each day of post-hospital recuperation the insurance amount specified in the Special Terms and Conditions. The period of payment for post-hospital recuperation cannot exceed 20 (twenty) days per event or 30 (thirty) days, respectively within the individual insurance coverage.

(9) In case of surgical treatment or surgical intervention, the Insurer pays the Insured the insurance payment representing the percentage of the insurance amount specified in the Special Terms and Conditions determined according to the „Table of Operations and Surgical Interventions“ representing Appendix No. 2 to these General Terms and Conditions. If the surgical treatment or surgical intervention is not explicitly indicated in the „Table of operations and surgical interventions“, it is equated in complexity to an existing position in the table.

(10) The Insurer has the right to refuse insurance payment if the number of days of hospital stay is higher than the one that is usual, necessary and inherent for the relevant treatment, monitoring or examination.

(11) If the Insured suffers an accident leading to fracture (breaking) or burn, the Insurer pays the Insured the insurance payment representing the percentage of the insurance amount specified in the Special Terms and Conditions determined according to the „Table of Fractures and Burns“ representing Appendix No. 3 to these General Terms and Conditions.

Article 15. Upon the renewal of the insurance contract, the Insurer covers the risk of all insurance events that have occurred during the validity of previous insurance contracts concluded with the Insurer, provided that the individual insurance coverage of the Insured has been uninterrupted and with the same covered risks.

SECTION V. BENEFICIARIES

Article 16. (1) The Policy holder is entitled to designate one or more beneficiaries. The rights of the beneficiaries are specified in the Special Terms and Conditions. In case of many beneficiaries, unless expressly agreed otherwise in the contract, their rights are equal.

(2) During the insurance period, the Policy holder may change the beneficiaries or add new ones.

Article 17. (1) Where the Special Terms and Conditions do not specify otherwise, the beneficiaries in case of death of the Insured are the legal heirs of the Insured. The heirs must be listed in the certificate of heirs, and the Insurer is not liable for claims of persons not included in this certificate.

(2) If the death of the Insured has occurred as a result of intentional act of a beneficiary, the insurance amount or the respective percentage thereof is paid to the other beneficiaries. If the beneficiaries are more than one, the part of the insurance amount due to the performer of the intentional act is distributed evenly between the other beneficiaries.

(3) Unless otherwise specified in the Special Terms and Conditions, the beneficiary for the risks of permanently reduced or lost work capacity, temporary loss of work capacity, medical expenses, daily allowance for hospital stay and/or daily allowance for post-hospital recuperation is the Insured. The insurance payments for these risks are personal, aimed at helping the Insured in difficult times, and therefore they are not inherited or owed to other persons regardless of whether they are legal heirs or beneficiaries upon death.

(4) If the Insured has not paid or is unable to pay the incurred medical expenses, the rights of the Insured as a beneficiary are acquired by the person who has performed or paid the service.

Article 18. If a beneficiary dies before the Policy holder, the Policy holder acquires the rights of such beneficiary under the contract.

SECTION VI. CONCLUSION, EFFECTIVENESS AND TERMINATION OF THE INSURANCE CONTRACT. RIGHTS AND OBLIGATIONS OF PARTIES

Article 19. (1) The insurance contract is concluded on the basis of an insurance application template of the Insurer filled out by the Policy holder.

(2) Upon the conclusion of the insurance contract, the Policy holder, the Insured and their proxies or insurance brokers are obliged to announce correctly and comprehensively the material circumstances known to them and of significance for the risk. „Material“ is a circumstance, for which the Insurer has explicitly put a written question.

(3) If the Policy holder, the Insured, their proxies of insurance brokers have deliberately announced incorrectly or have concealed a circumstance under which and having known this circumstance the Insurer would not have concluded the contract, the Insurer may terminate the contract within one month after becoming aware of this circumstance. In this case, the Insurer retains the paid portion of the premium and has the right to require its payment for the period until the termination of the contract.

(4) Where the deliberately disclosed or concealed incorrect circumstance is of such nature that the Insurer would have concluded the insurance but under different conditions, the Insurer may require amendment of the contract. This right may be exercised within one month of becoming aware of the circumstance. In case the Policy holder does not accept the proposal for amendment within two weeks from its receiving, the contract is terminated with the consequences under the previous paragraph 3.

(5) Where an insurance event has occurred in the cases under paragraphs 3 and 4, the Insurer may refuse to pay the insurance amount entirely or partially, only if the incorrectly announced or concealed circumstance has influenced the occurrence of the insurance event. Where the circumstance has only increased the damage, the Insurer cannot refuse the payment, but may reduce it according to the ratio of the size of paid premium to the premium that had to be paid according to the actual insurance risk.

(6) If upon the conclusion of the insurance, the circumstance had not been known to any of the parties, each party may request a written amendment of the contract within two weeks of learning about the circumstances. In case the other party did not accept the proposal within two weeks of its receiving, the proposing party can terminate the insurance with a written notice to the other party. In case the Insurer reimburses the part of the paid premium corresponding to the non-expired period of the insurance contract. Upon occurrence of the insurance event before the amendment or termination of the contract, the Insurer cannot refuse the payment, but may reduce it according to the ratio of the size of paid premium to the premium that had to be paid according to the actual insurance risk.

(7) During the term of the insurance contract, the Insured is obliged to announce before the Insurer all newly arising circumstances about which the Insurer has put written questions. The announcement of the circumstances must be made immediately after their learning. In case of non-fulfilment of the obligation, the consequences of the previous paragraphs apply.

Article 20. The insurance contracts may be individual or group contracts.

Article 21. (1) The individual insurance contracts are concluded with healthy persons at normal insurance risk. Individuals at aggravated insurance risk according to the criteria listed in the health status declaration are insured under terms and conditions determined by the Insurer and specified in the insurance contract and/or against an increased premium.

(2) Upon conclusion of an individual insurance contract, the application under Article 19, paragraph 1 is accompanied by the following documents:

1. Insurer's template of health status declaration filled out and signed personally by the applicant for insurance, including information about the profession and occupation of the Insured, while the Insurer is entitled to request other information and documents necessary for the assessment of the insurance risk;

2. an identity document, as well as documents required by the current legislation or by the Insurer's internal rules.

(3) The Policy holder may conclude an individual contract for Risk Life insurance, the subject of which is the life, health or bodily integrity of another individual (Insured). This contract is effective only if it is concluded with the express written consent of the Insured. The Insured may at any time terminate the insurance contract with a unilateral written statement addressed to the Insurer.

Article 22. (1) Upon conclusion of a group insurance contract, the application under Article 19, paragraph 1 must be also accompanied by:

1. list of the names of the insured persons provided by the Policy holder containing their three names, personal identity numbers and other legal individualizing information.

2. other documents required by the current legislation or by the Insurer's internal rules.

(2) The Policy holder has the right to update the list of the insured persons during the contract period by providing the Insurer the updated data in writing and in accordance with the Special Terms and Conditions. The Insurer is notified about changes of the list in one of the following manners:

1. Under the conditions of explicit notification – in this option, the Policy holder sends information to the Insurer about any change in the list of persons insured under the contract, and the Insurer's liability arises from 00.00 hours on the date of their inclusion in the list of names of the insured persons and is terminated at 24.00 hour, respectively on the date of their exclusion from the list of names of the insured persons;

2. Under the terms of advance insurance – the insurance contract is concluded on the basis of submitted information requested by the Insurer, while within the terms specified in the Special Terms and Conditions, the Policy holder undertakes to provide the Insurer with detailed information about changes in the list of insured persons. In this option, the Insurer undertakes to bear in advance the risk for the newly employed employees of the Policy holder, who will later be included in the list, from the date of registration of their contracts at the NRA, while in case of an insurance event with an employee, the Policy holder/the Insured is obliged to notify the NRA. Where a replacement of insured persons is done, the insurance coverage of the dismissed person terminates on the date of the dismissal and the employed person takes its place subject to the principle stated in the previous sentence.

(3) The insurance premium for newly employed employees is calculated proportionally for the period remaining until the end of the contract in full months. The unused insurance premium for persons excluded from the list is recalculated proportionally for the period remaining until the end of the contract in full months.

(4) In the cases under paragraph 3, for each started calendar month of the contract period, an insurance premium is due for a whole month, while the changes in the premium reflected in each addendum for changes in the list of insured persons are reflected in the settling of the premium, which takes place one month after the expiration of the contract period.

(5) If there are no updates for a preceding period, in case of changes in the list of insured persons upon conclusion of an insurance contract under the terms of advance insurance, the latest list of insured persons sent by the Policy holder with all reflected changes is deemed the up-to-date list.

(6) The insurance contract may also be concluded without the list of names, if the Policy holder is an employer and all employees and workers are insured according to an average list.

(7) Where the employer concludes on its expense a group insurance on the life, health and bodily integrity of its employees and/or workers for their benefit or for the benefit of their heirs, the consent of the workers and employees for the conclusion, amendment and termination of the insurance is not required.

(8) Depending on the number of group members, the insurance coverage, the age of the Insured, the insurance amount and the submitted information, the Insurer is entitled, prior to signing the insurance contract, to require filling out of a health status declaration and medical examinations and/or tests of the applicant(s) for insurance. The medical examination is carried out by a trusted for the Insurer physician/medical facility in a manner specified by the Insurer.

Article 23. (1) The insurance contract enters into force from 00:00 hours on the date specified in the Special Terms and Conditions as the beginning of the insurance coverage period and provided that the insurance premium or the first installment thereof has been paid, unless otherwise agreed.

(2) Acceptance of the policy by the Policy holder is possible up to 1 month from the date of its issuing and is effected by handing it to the Policy holder by a representative or a broker of the Insurer against signature and payment of the premium or the first installment thereof. If the policy is not accepted within one month under this paragraph, the issued Policy is cancelled by the Insurer and the paid premium is returned.

(3) The insurance coverage is terminated at 24:00 hours on the date specified by the insurance contract as the end of the period.

Article 24. (1) The parties to the contract cannot amend the contract unilaterally, except in the cases provided for in the contract.

(2) The Policy holder has the right to make the following amendments of the Special Terms and Conditions, which, if accepted by the Insurer, are effective from the date specified in the addendum:

1. amendment of the insurance amount:

1.1. if amendment leading to reduction of the insurance premium is requested, this reduced amount must correspond to the requirements for minimum premiums of the Insurer;

1.2. if amendments leading to increasing of the insurance amount are requested where the contract is concluded with assessment of the insurance risk, the Insured must attest his/her health status by means of health status declaration, as well as his/her profession and occupation according to the template of the Insurer. If the request for increase of the insurance amount falls within the limit, which according to the requirements of the Insurer, requires medical examinations, the Insured must carry put the examinations according to the instructions of the Insurer.

2. change of the periodicity of the premium installments, while their new amount must correspond to the requirements of the Insurer for minimum amount.

3. change of beneficiaries;

4. change of the Policy holder, which is possible only after the Insurer has received the explicit written consent of the previous Policy holder and the new Policy holder, and case of individual insurance contract, the explicit written consent of the Insured.

(3) The Policy holder may request amendment of the Special Terms and Conditions under paragraph 2, items 1 and 2 the application is filed at least one month before the pending maturity, from which the requested amendment will enter into force. The amendments are done by means drafting and signing an addendum to the contract by the parties to the contract.

(4) In case of an individual insurance contract and death of the Policy holder before the Insured, any person having a legal interest may replace the Policy holder, unless the parties have agreed otherwise. The replacement is effected by a written notice to the Insurer from the interested person, accompanied with the death certificate of the Policy holder.

(5) In case of legislative changes or other changes of circumstances beyond the control of the Insurer, the consequences of which could not have been anticipated and which could lead to significant changes in the conditions for providing insurance protection under the insurance contract, the Insurer may offer the Policy holder amendments of the tariffs and conditions of the policy. The amendment becomes effective upon consent of the Policy holder. If no consent is given in writing and explicitly within 15 (fifteen) days from the date of receipt of the application, the insurance contract is terminated upon the expiration of the 15 days period.

(6) The Insurer is entitled to deduct from the policy payments any expenses incurred by it in connection with unfair conduct on the part of the Policy holder/the Insured.

Article 25. (1) The insurance contract is terminated with the expiration of the insurance period, in case of death of the Insured if the insurance contract is individual, if the insurance limit is utilized, or in other cases provided for by the Insurance Code or the contract.

(2) The contract may be terminated before the expiration of the insurance term in the following cases:

1. by a unilateral statement by the Policy holder to the Insurer, where the insurance interest has ceased during the term of the contract;

2. if the Insured has objected in writing against the conclusion of the contract on his life before the Insurer - from the date of receiving the objection;

3. if the Policy holder dies before the Insured and before having paid the entire insurance premium (unless otherwise agreed) and no change has been effected under Art. 24, paragraph 4;

4. in case of non-payment of a deferred installment within the agreed deadline, the insurance contract is terminated at 24:00 hours of the 15-th day from the maturity date of the deferred installment.

5. with mutual written agreement between the parties.

(3) Any person who has concluded a life insurance contract with a period of more than 6 (six) months has the right to terminate it unilaterally within 30 (thirty) days from the date of conclusion of the contract.

(4) The Policy holder may at any time exercise the right to terminate the insurance contract with a unilateral written statement addressed to the Insurer. From the date of receipt of the notification by the Insurer, the insurance contract is terminated and the Policy holder is released from the contract obligations and is entitled to receive the paid insurance premium back, less the portion corresponding to the time the Insurer has carried the risk, if no insurance event has occurred. The Insurer returns the relevant portion of the premium within 30 days from the receiving of the written notice under the first sentence.

SECTION VII. INSURANCE PREMIUM

Article 26. (1) The amount of the insurance premium is specified in the Special Terms and Conditions of the contract. It depends on the covered risks under the contract, the insurance period, the insurance amount, the age of the Insured and the data stated in the declaration about the health status, the profession and the occupation of the Insured, if such is required.

(2) The insurance premium and the insurance amounts are determined in the same currency.

Article 27. (1) The insurance premium under this insurance is annual. The annual premium becomes due at the beginning of the insurance year to which it relates. The annual insurance premium may be deferred to installments as specified in the contract. If the annual premium is paid in installments (i.e. in equal installments more frequent than annual), the one-year series of deferred premium installments becomes due at the beginning of the insurance year, while each successive installment becomes due on the maturity date specified in the Special Terms and Conditions.

(2) The insurance premium is paid:

1. before the beginning of each insurance period of one year or in deferred installments, while the first installment is paid upon the conclusion of the contract and the next ones (is any) are paid as specified in the contract.

2. in the currency specified in the insurance contract, or in the BGN equivalent according to the fixing of the Bulgarian National Bank as of the date of the payment (the maturity) in the cases where the amount is paid to the bank account of the Insurer. In all other cases, this equivalent is determined by the exchange rate of the servicing bank.

(3) All extra premiums at the expense of the Policy holder must be paid simultaneously with the premium.

(4) If the insurance risk significantly increases or decreases during the insurance contract period, either party may claim an increase or decrease in the insurance premium or may request termination of the contract. If the change is not accepted by the other party, the contract may be terminated.

Article 28. (1) The insurance amount is paid by bank transfer, direct debit or otherwise, as agreed between the parties. As a date of payment, the value date of the due amount in the

Insurer's bank account is considered.

(2) in case of non-payment of a deferred installment within the agreed deadline, the Insurer is entitled to terminate the contract on the 15-th day from the maturity date of the deferred installment.

(5) In case of individual insurance contracts and occurrence of an insurance event before the full payment of the insurance premium, the Insurer may offset the unpaid premium against the due indemnity.

SECTION VIII. INTERACTION IN CASE OF AN INSURANCE EVENT

Article 29. (1) Upon occurrence of the insurance event, the Insured, its representative or its legal heirs are obliged to inform the Insurer in writing and submit the following documents (originals or certified copies) related to the confirmation of the respective event and the insurance amount.

1. Application for payment of an insurance amount – template of the Insurer;

2. Special Terms and Conditions of the insurance policy and eventual addenda thereto;

3. Copy of the identity document of the Insured or the beneficiary, respectively;

4. Documents evidencing the date, the cause and the circumstances of occurrence of the insurance event or evidencing the consequences for the Insured: a detailed written description of the accident in the case of a home accident; report for occupational accident; Declaration for an occupational accident and other official certification documents confirming the occurrence of the insurance event; report issued by the Traffic police, forensic medical examination, copy of the autopsy report, result of an alcohol test, court rulings, personal outpatient card of the Insured, outpatient examination and consultation sheets, test results, incl. specialized tests and conducted treatment, epicrisis from death, as well as other epicrisis from conducted hospital treatment of the Insured; medical certificates and certificates from various bodies and institutions, etc.;

5. Information from the employer about the occurrence of an insurance event (only for group insurances made on the expense of the employer);

6. Bank account certificate of the Insured or the beneficiaries, respectively;

7. In case of death: in addition to the documents from item 1 to item 6, also a transcript-extract of death certificate, death notice, certificate of heirs;

8. In case of permanently reduced or lost ability: in addition to the documents from item 1 to item 6, also a an effective decision of TEMC/NEMC;

9. In case of temporary loss of work capacity: in addition to the documents from item 1 to item 6, also:

9.1. sick leaves (certified by the employer as „вярно с оригинала“ (true to the original) and confirmation that the sick leaves were actually used), while the duration of the temporary loss of work capacity is determined by the period specified in the sick leave and its extensions. The beginning of the primary sick leave must be within the insurance year, while subsequent sick leaves must be issued as extensions of the primary one and must be uninterrupted and/or

9.2. report issued by the Medical Consultancy Committee (MCC) stating the diagnosis, the duration of the treatment and the period for recovery of the work capacity;

10. In case of medical expenses: in addition to the documents from item 1 to item 6, a medical form filled in by the physician performing the treatment; prescriptions for medications; original invoices for the incurred expenses together with a receipt for these; epicrisis from a medical facility, sick leave note or a reference from the National Social Security Institute for actually used sick leave, as well as other documents depending on the incurred expenses.

(2) The Insurer may require other documents for assessment of the filed claim and decision.

(3) Permanently reduced or lost work capacity and temporary work incapacity must be certified with official documents issued by authorized Bulgarian authorities, even if they occurred outside the territory of the Republic of Bulgaria and/or with an Insured Person residing outside the territory of the Republic of Bulgaria.

(4) The beneficiary is obliged to submit the requested documents related to the confirmation of the event and the determination of the insurance amount. The Insurer may refuse to pay the insurance amount if the beneficiary has submitted untrue or altered evidence or documents.

Article 30. (1) The insurance amount or the percentage thereof is paid within 15 (fifteen) business days from the date of submission of all required documents to the Insurer.

(2) Where further evidence is needed to clarify the causes and the circumstances of the occurrence of the insurance event, which evidence has not been provided for in the insurance contract upon its conclusion, and which is necessary for establishing the grounds and the amount of the insurance claim, the Insurer informs the Insured/the beneficiaries about such further evidence at latest within 45 (forty-five) days after the submission of the evidence determined in the insurance contract.

(3) Where not all evidence necessary to establish the insurance claim in terms of grounds and amount has been provided, the Insurer is obliged to rule on the claim no later than 6 (six) months from the date of its submission.

(4) The insurance amount is paid to the Insured/the beneficiaries to Bulgarian bank accounts specified by them.

If the Insured/the beneficiary wishes to transfer the insurance amount to an account outside the Republic of Bulgaria, the costs of the transfer is at the expense of the Insurer/ the beneficiary.

(5) Payment to the person having the right to receive the amount or indemnity through proxy is allowed only on the basis of an explicit written power of attorney with notarized signature for the respective insurance claim, containing a statement that the person (the principal) is informed about its right to receive the payment in person.

(6) If the insurance amount is determined in foreign currency and the payment is made in Bulgaria, the Insurer may pay its BGN equivalent, if so agreed. This equivalent is determined by the fixing of the Bulgarian National Bank as of the date of the payment, unless another exchange rate is agreed.

SECTION IX. OTHER PROVISIONS

Article 31. (1) Upon conclusion of the insurance contract, the Policy holder provides an address for correspondence and selects its type – postal or electronic. The initially specified address for correspondence can be changed during the insurance contract period, while such change can be made at any time and no fee is due for it. All notifications to the Policy holder are sent to the last known address given in written to the Insurer. The obligation of notification of the Insurer is deemed fulfilled if the Insurer has sent the notification to the last known address for correspondence of the Policy holder.

(2) The date of the notification is considered to be:

1. in case of postal correspondence – the date of receiving of the letter. This rule does not apply when the Policy holder has not notified the Insurer about the changes of his postal address for correspondence. In this case, the outgoing date of the letter is deemed as date of the notification.

2. in case of email correspondence – the date of receipt of the message in the specified electronic system. The receiving of the e-mail is certified by a copy of the electronic record (e-mail printout).

(3) The notifications to the Insurer must be in writing and sent by post to the Insurer's correspondence address or submitted personally at each of its offices.

Article 32. In case of loss or destruction of the policy, the Policy holder must notify the Insurer immediately in order to obtain a certified copy thereof. The Policy holder receives the copy against a declaration of invalidity of the lost/destroyed policy and payment of a EUR 10 (ten) fee.

Article 33. (1) Solely Owned Joint Stock Insurance Company (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD in its capacity of a data controller protects the personal data in accordance with the requirements of Regulation (EU) 2016/679 of the European Parliament, the Personal Data Protection Act and the Internal Rules and Policies of the Insurer. The provided personal data are used by the Insurer for the purposes of concluding, administration, fulfilling of obligations and settlement of claims under insurance contracts. Information about the purposes and the terms for processing of personal data is published on the official website of the Insurer: www.bulstradlife.bg.

(2) When concluding insurance contracts, as well as during the contract term, the Insurer is entitled to receive detailed and accurate information regarding the following categories of personal data: age; gender; health and financial status of the individual; whose life, health or bodily integrity is subject to insurance.

(3) Upon the occurrence of an insurance event, the Insurer has the right of access to personal data contained in all medical records in relation to the health status of the individual whose life, health, and bodily integrity are insured by the Insurer, and may require it from all persons keeping such information, including under the Medical Facilities Act, the Health Insurance Act and the Health Act for the purpose of fulfilling its obligations under the insurance contract.

(4) The Insurer is not entitled, without the consent of the individual concerned, to disclose to third parties any known personal data, except in the cases provided by the law or for

prevention of insurance frauds or in relation with the Measures Against Money Laundering Act.

(5) The provision of personal data is entirely voluntary. The refusal to provide personal data is grounds for the Insurer to refuse to conclude a contract or to act otherwise if the absence of such data does not enable objective assessment of the risk of the transaction or otherwise endangers the realization of the legitimate interests of the Insurer.

(6) Any data subject has the right of access to them and is free to exercise his/her rights in accordance with the applicable personal data protection law and the Internal Rules of the Insurer.

Article 34. Provided that this clause does not violate any specific national law or regulation applicable to the Insurer, and notwithstanding the terms and conditions of this insurance contract, the Insurer does not provide coverage, is not liable to pay insurance indemnity, and does not provide other services, as far as such coverage, indemnity or service would expose the Insurer to a risk associated with commercial, financial, embargo or economic sanctions, laws or regulatory requirements applied by the Insurer.

(2) The applicable commercial, financial, embargo or economic sanctions may be as follows:

- a) national sanctions;
- b) sanctions of the European Union (EU);
- c) sanctions of the United Nations (UN);
- d) sanctions of the United States of America (USA);
- e) sanctions of the UK;
- f) other sanctions.

(3) Where it is established that a party to the insurance contract is on the above consolidated sanctions lists, the Insurer terminates the contract immediately from the moment of becoming aware of this.

Article 35. The rights and the obligations under the insurance contract concluded under these General Terms and Conditions are lapsed with the expiration of 5 years from the date of the occurrence of the insurance event.

Article 36. No compulsory sequestration is allowed upon the insurance amount.

Article 37. The disputes between the parties are resolved by mutual agreement and, where impossible – before the competent Bulgarian court. The applicable law is the Bulgarian law.

Article 38. All taxes, fees, etc. existing or pending to be imposed upon the received insurance payment are at the expense of the beneficiaries, the Insured or their heirs.

Article 39. (1) These General Terms and Conditions are an integral part of the insurance contract.

(2) Subsequent amendments and appendices to these General Terms and Conditions enter into force only for insurance contracts concluded after the date of the amendment and do not affect the existing contracts, unless a change in a regulation requires it or the parties agree otherwise.

FINAL PROVISIONS

§1. These General Terms and Conditions of Risk Life insurance have been adopted at a meeting of the Board of Directors of ZAD BULSTRAD LIFE with MoM No. 71 of 07.05.2003 and have been approved by letter of the Insurance supervision directorate at the FSC with ref. No. 22-02-03 of 23.04.2003.

§2. These General Terms and Conditions have been amended by MoM 84/15.11.2004 at a meeting of the Council of Directors of Bulstrad Life AD, supplemented by decision under MoM No. 280/05.03.2020 of a meeting of the Management Board of SOLELY OWNED JOINT STOCK INSURANCE COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD, amended and supplemented by a decision under MoM No. 377/ 19.10.2023 of a meeting of The Management Board of SOLELY OWNED JOINT STOCK INSURANCE COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD.

DECLARATIONS BY THE POLICY HOLDER/THE INSURED IN RELATION WITH THE SIGNING OF POLICY NO.:

The insurer provided me these General Terms and Conditions upon the signing of the insurance application. I am acquainted with them, I agree, and I accept them.

Policy holder:
(company name, UIC)

Insured: Date: Signature:
(name, surname, family name)