

SECTION I. DEFINITIONS

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

- 1. 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 law is the subsidiary applicable law.
- 2. 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 changes 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. Where the life of the Policy holder is insured, then the Policy holder is also Insured.
- 7. Insured** is the individual, resident of the European Union, on whose health and bodily integrity the insurance is concluded.
- 8. Beneficiary** is the person entitled to receive the insurance payment upon the occurrence of an insurance event. The beneficiary is specified in the insurance contract.
- 9. Term of the insurance** is the term, for which the insurance contract is concluded. Its beginning and end are specified in the Special Terms and Conditions.
- 10. Insurance coverage period** is the period for which the Insurer covers the insurance risks.
- 11. Waiting period** is the period after the date of conclusion of the contract for which the beginning of the insurance coverage is delayed, and during which the Insured cannot benefit from the insurance coverage.
- 12. Insurance period** is the period, for which the insurance premium is determined. The insurance period may be one year or may coincide with the insurance coverage period. For the insurances with annual insurance premium, 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. 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.
- 15. 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.
- 16. Insurance amount** 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.
- 17. 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.
- 18. 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 (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.).
- 19. Self-inflicted condition** is an insurance event due to a deliberate harm to the won health committed by the Insured or by any of the beneficiaries, or at their instigation;
- 20. Pre-existing illness, disability or condition** is illness or medical condition, for which the insured has been treated, has sought medical advice or has learned about its existence before the beginning of the insurance period.
- 21. 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.
- 22. 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.
- 23. Address for correspondence** is a postal or e-mail address specified by the Insured in the insurance application 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 „Critical illnesses“ insurance, and against paid insurance premium, the Insurer insures individual(s), hereinafter referred to as the Insured person(s) against events related to the life, health or bodily integrity.

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. The aggravated risk may be expressed in the individual or combined application of the following methods: change of the insurance premium, change of the risk rate, change of the insurance period, exclusion or restriction of certain risks, or use of other methods agreed upon the conclusion of the insurance.

- (2) The age of the Insured by the date of effectiveness of the contract must be between 18 (eighteen) and 60 (sixty-four) years, determined in whole years by the beginning of the insurance coverage.
- (3) By the date of expiration of the insurance, the age of the Insured must not exceed 65 (sixty-five) full years.
- (4) On the anniversary of the insurance policy in the year in which the Insured reaches the age indicated in paragraph 3, the insurance coverage is terminated.
- (5) This insurance is concluded as a supplementary insurance to „Life“ insurance, term „Life“ insurance, and „Life“ insurance linked to investment fund.
- (6) „Critical illness“ insurance cannot be surrendered by the Policy holder.

SECTION III. TERRITORIAL SCOPE

Article 4. (1) The Insurer provides insurance coverage worldwide, unless otherwise agreed in the Special Terms and Conditions.

SECTION IV. COVERED AND EXCLUDED RISKS

Article 5. (1) Definitions of covered illnesses, events and conditions and related exclusions:

1. Surgery of the aorta

1.1. Means underwent surgery to restore or partially prostrate the aorta due to an aortic aneurysm, coarctation or traumatic aortic rupture. For the purpose of this definition, „aorta“ means the thoracic or abdominal aorta, but not its branches.

1.2. Exclusion: The insurance does not cover any other surgical procedure, such as endovascular restoration or stent implants.

2. Benign brain tumour that has led to intensive treatment or palliative care

2.1. Means a benign, but life-threatening brain tumour. The condition for payment of insurance indemnity is the meeting all of the following criteria:

2.1.1. The presence of a tumour must be proven by magnetic resonance imaging (MRI), computed tomography (CT) or other appropriate imaging;

2.1.2. There must be severe consequences, such as intracranial pressure, new epileptic seizures, motor and sensory disorders, which can be objectively proven.

2.2. The tumour must have:

2.2.1. led to surgical intervention for its complete removal or its reduction as much as possible and

2.2.2. been treated with either chemotherapy or radiation therapy, or

2.2.3. reached a stage where only palliative care is possible.

2.3. Exclusion: The insurance does not cover cysts, calcifications, granulomas, malformations of cerebral arteries, or veins, or hematomas.

3. Blindness – irreversible

3.1. Means clinically proven irreversible reduction of the vision of both eyes due to an illness or traumatic accident.

3.2. The condition for payment of insurance indemnity is the meeting of all of the following criteria:

3.2.1. The corrected visual acuity of the better eye must be less than 0.2 on the decimal system, or there must be a visual field limitation of less than 10° diameter for each eye;

3.2.2. The diagnosis must be confirmed by an ophthalmologist.

3.3. Exclusion: Insurance indemnity is not due if, according to the general medical opinion, the use of medical devices, implants or any other treatment methods and means could lead to a partial or complete restoration of the vision.

4. Implanting a bypass graft to a coronary artery

4.1. Means implanting an aorta-coronary graft on a coronary artery, which corrects a proven narrowing or blockage of at least one coronary blood vessel.

4.2. Exclusion: The insurance does not cover balloon angioplasty; atherectomy; rotablation; stent implants; laser treatment.

5. Myocardial infarction with cardiac function impairment

5.1. Means necrosis (death) of the heart muscle in a certain limited area due to blockage of one or more coronary arteries. It is confirmed by the presence of all of the following symptoms:

5.1.1. New, characteristic changes in the ECG or other imaging diagnostic tests confirming the occurrence of acute myocardial infarction;

5.1.2. Transient increase of cardiac troponin T or I, or of cardiac enzymes, including creatine kinase MB fraction, above the generally accepted laboratory reference values for myocardial infarction;

5.1.3. Evidence of permanently reduced left ventricular ejection fraction below 50% due to a myocardial infarction, measured at least one month after the event.

5.2. Exclusion: The insurance does not cover:

5.2.1. Any event, including acute coronary syndrome, which has not been confirmed by

a cardiologist or other physician-specialist in the field as an acute myocardial infarction, including angina pectoris, but without the presence of acute myocardial infarction;

5.2.2. Myocardial infarction with unknown time of occurrence;

5.2.3. Increase of cardiac biomarkers, which is directly related to intra-arterial cardiac procedure, which includes, but is not limited to coronary angiography and coronary angioplasty.

6. Surgery of the heart valves

6.1. Means an open-heart surgery performed by thoracotomy (opening of the chest) to implant prosthetic or correct at least one heart valve due to a heart valve defect or anomaly of the heart valves.

7. HIV through blood transfusion

7.1. Means infecting the Insured with Human Immunodeficiency Virus (HIV) provided that:

7.1.1. the infection is due to a blood transfusion after the date of entry into force of the contract, and

7.1.2. the institution providing the blood transfusion has assumed responsibility or there is an enforceable ruling establishing such liability, and

7.1.3. the infected Insured is not a haemophiliac.

7.2. Exclusion:

7.2.1. Insurance indemnity is not due if medical treatment for AIDS or for the effects of the HIV virus is discovered.

7.2.2. Indemnity is not due for any other ways of infection, including infections resulting from sexual contact or intravenous intake of narcotics.

8. Kidney failure

8.1. Means chronic, irreversible functional insufficiency of both kidneys requiring regular dialysis treatment or kidney transplantation. The diagnosis must be confirmed by a nephrologist.

9. Cancer

9.1. Means any malignant tumour characterized by uncontrollable growth and spreading of malignant cells and invasion of tissues. The diagnosis must be supported by histological or, in cases of systemic cancer, cytological evidence.

The term "malignant tumour" also includes: leukaemia, lymphoma (excluding cutaneous lymphoma), sarcoma.

9.2. Exclusion:

9.2.1. Cancer in situ;

9.2.2. Information about cancer cells or cancer genetic material gathered solely by molecular or biochemical probes (which include, but are not limited to proteomic or DNA/RNA-based techniques), without the presence of lesions subject to tissue diagnosis;

9.2.3. Any basal cell carcinoma, non-melanoma skin cancer and melanoma in situ;

9.2.4. Malignant illnesses histologically defined as stage pT1apN0M0 (TNM classification, where T is the size of the tumour; N - scattering in nearby lymph nodes; M - distant metastases) or earlier;

9.2.5. Any papillary carcinoma of the thyroid gland, which is histologically described as stage T1N0M0 (according to the TNM classification) or earlier;

9.2.6. Any malignant illness of the blood, bone marrow or lymph nodes that does not require recurrent blood transfusions, systemic chemotherapy, targeted anticancer therapies, bone marrow transplantation, hematopoietic stem cell transplantation or other significant interventional treatment;

9.2.7. Any neuroendocrine tumour (NET) and neoplasm (NEN), which is histologically described as stage G1, PanNETG1, T1N0M0 (according to the TNM classification) or earlier;

9.2.8. Any gastrointestinal stromal tumour, which is histologically described as stage T1N0M0 (according to the TNM classification) or with a mitosis rate <6 per 50 hpf.

9.2.9. Cancer is not considered any illness or condition described or classified as any of the following, namely: with borderline malignancy or low malignant potential; dysplasia and intra-epithelial neoplasm, such as cervical dysplasia CIN-1, CIN-2 or CIN-3, where CIN means cervical intraepithelial neoplasia, etc.

10. Transplantation of important organs

10.1. Means a human-to-human transplant of a kidney, heart, lung, pancreas or at least one whole liver part from a donor to the insured.

10.2. **Exclusion:** Autologous transplantation and transplantation of any organs other than those listed in item 10.1, as well as parts of organs (excluding a part of a liver), tissues or cells are excluded from the insurance coverage scope.

10.3. The need for organ transplantation, as well as the performance of the transplantation must be confirmed and justified by relevant medical documents issued by a specialized medical facility. The condition requiring transplantation must be classified as untreatable in any other manner.

11. Cerebral stroke or infarction with neurological deficiency

11.1. Means loss of central or spinal cord tissue in a limited area due to acute non-traumatic bleeding or ischemia inside the cranial cavity or the spine, which leads to permanent and irreversible neurological deficiency with persistent clinical symptoms.

11.2. The condition for payment of insurance indemnity is the meeting of all of the following criteria:

11.2.1. The diagnosis must be supported by imaging (e.g. computed tomography (CT), magnetic resonance imaging (MRI) proving the relation between the newly acquired neurological deficiency and the newly identified affected areas in the cranial cavity and the

spine;

11.2.2. Evaluation of the permanent irreversible neurological deficiency may be performed not earlier than 3 (three) months after the occurrence of the stroke.

11.3. Exclusion:

The insurance does not cover:

11.3.1. Acute transient disturbance of cerebral circulation, i.e. temporary disturbance of blood circulation to part of the brain. The symptoms are the same as those of the stroke, but the person recovers within 24 (twenty-four) hours;

11.3.2. Stroke with unknown time of occurrence;

11.3.3. Stroke diagnosed only on the basis of biomarkers;

11.3.4. Stroke affecting only the sense of smell or the optic nerve, or retinal stroke.

12. Paralysis – complete, affecting any two limbs

12.1. Means clinically proven complete and irreversible loss of muscle function of any two limbs due to an accident or illness.

13. Severe burns

13.1. Means tissue damage caused by thermal, chemical or electrical agents leading to a third degree burn or burns through the entire depth of the affected area of at least 20% of the whole body surface measured by „Multiples of 9“ or the Lund-Browder Body Surface Chart.

14. Coma lasting at least four days

14.1. Means an unconscious state with lack of or response to external stimuli or internal needs continuing for at least 96 (ninety-six) hours and requiring the use of life-support systems. Medical indications for artificial coma must be confirmed by a certified medical professional.

14.2. Insurance indemnity will also be paid for coma without the use of life support systems lasting at least two months.

14.3. **Exclusion:** The insurance does not cover coma caused by alcohol and narcotics abuse.

15. Occupational HIV infection

15.1. Means infecting with Human Immunodeficiency Virus (HIV) where the infection is due to:

15.1.1. accident during the execution of normal employment duties,

15.1.2. handling of blood or other body fluids within employment and professional duties.

15.2. The condition for payment of insurance indemnity is the meeting of all of the following criteria:

15.2.1. The infection must have occurred during the execution of the professional duties of the Insured was, while the occupation of the Insured must be included in the list below;

15.2.2. The seroconversion must occur within 6 (six) months of the incident;

15.2.3. The Insured must provide negative results of HIV or HIV antibodies tests performed within five (5) days after the reported incident;

15.2.4. The presence of HIV or HIV antibodies must be proven within 12 (twelve) months after the incident.

15.3. The coverage for this risk is limited to the following occupations:

15.3.1. Physicians and dentists;

15.3.2. Assistants- physicians and assistant-dentists;

15.3.3. Nurses;

15.3.4. Midwives;

15.3.5. Laboratory personnel;

15.3.6. Assistant hospital personnel;

15.3.7. Personnel working in ambulances;

15.3.8. Firemen;

15.3.9. Policemen;

15.3.10. Personnel in detention facilities;

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

Article 6. Waiting period

(1) The insurance provides for a „Waiting Period“ of 90 (ninety) days from the date of entry into force of the insurance contract or from the date of renewal of the insurance contract. No „Waiting period“ applies where the risk covered by the insurance policy has occurred due to an accident.

Article 7. Maturity period

(1) Insurance payment under these General Terms and Conditions is due where the Insured is alive within at least 28 (thirty) days of the occurrence or diagnosis of the condition defined as „Critical illness“ according to these General Terms and Conditions. In case of death of the Insured during the maturity period, the Insurer does not owe insurance payment under these General Terms and Conditions.

Article 8. Excluded risks

(1) The Insurer does not cover the risks under Art. 5, related to the impairment and/or the deterioration of the health and bodily integrity of the Insured in the following cases:

1. under contracts, upon whose conclusion the Insured has filled out the Insurer's template of declaration for health status, if the events are directly or indirectly due to a pre-existing disease or condition not disclosed by the Insured in the insurance application;

2. under contracts, upon whose conclusion the Insured has not filled out the Insurer's template of declaration for health status, if the events are directly or indirectly due to a pre-existing disease or condition;

3. objective information has existed that would make every reasonable person to seek medical help or advice by a qualified medical practitioner.

(2) The Insurer does effect payments under this insurance and the insurance indemnity is

respectively not due, if the first appearance of the symptoms or the first diagnosis of the illnesses under Art. 5, or the performed surgery, respectively, occurs within the waiting period under Art. 6 or is within 90 (ninety) days from the date of renewal of the contract after its termination.

(3) Under these General Terms and Conditions, no insurance payments are effected in case of events with the Insured, which directly or indirectly cause or aggravate his/her condition and which are due to:

1. attempted suicide;
2. self-inflicted condition;
3. committing or attempting to commit a crime of a general nature by the Insured while the Insured is detained by the authorities or is in prison;
4. deliberate acts of the Insured resulting in the occurrence of a critical illness or condition of the Insured. If there are several beneficiaries, this exception applies only to the actions of the perpetrator;
5. war or military actions (regardless whether the war is announced or not), rebellion, coup d'état, 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, riot, revolution, civil unrest or violence, rebellion, insurrection;
6. participation in armed forces or peacekeeping activities;
7. 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;
8. 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;
9. involvement of the Insured in bets or challenges, a fight provoked by the Insured or a fight, in which the Insured was involved actively and voluntarily; hooligan actions of the Insured;
10. handling of weapons and explosives;
11. practicing high-risk occupations and activities, incl. sports and hobbies, which the Insured has not disclosed upon the conclusion of the insurance or during its term, and which have not been explicitly accepted by the Insurer against the payment of an additional premium (all kinds of motor, flying, aeronautical, water and underwater sports and activities; jumps from heights; climbing requiring special equipment, and speleology or winter sports practiced outside the places designated for their exercise);
12. professional exercising by the Insured of any kind of sports, including participation in training and sports competitions, unless the insurance contract provides otherwise.
13. 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;
14. use of alcohol, narcotics, opiates or stimulants by the Insured;
15. infection with any Human Immunodeficiency Virus (HIV) or presence of any HIV antibodies in the body of the Insured, or the Insured suffers from Acquired Immune Deficiency Syndrome (AIDS), excluding the cases covered by Art. 5, items 7 and 15;
16. participation in medical or scientific research, or clinical tests of medical products, experimental or research services;
17. events occurred when the Insured has violated laws or bylaws in force.

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

Article 9. (1) The contracts for „Critical illnesses“ insurance are individual or group contracts.

Article 10. (1) The individual contract is concluded on the grounds of an insurance application template, which also includes a declaration about the health status of the Insured, as well as other data and information, including medical and financial information that the Insurer may require for assessment of the insurance and financial risk.

(2) In order to conclude an insurance contract, besides the information under the previous paragraph, the Policy holder must present an identity document and must fill out/present the respective documents required by the applicable law.

(3) Depending on the insurance coverage, the age of the Insured, the insurance amount and the information stated in the declaration about the health status, the Insurer may require medical examinations and/or tests of the Insured. These are performed by a physician/ medical facility according to the requirements of the Insurer.

(4) The Policy holder may conclude a contract on the life, health or bodily integrity of another person (insured). This contract is effective only if concluded with the explicit 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 11. (1) If, due to objective reasons, the insurance contract is not concluded within 3 (three) months after the signing of the declaration under Art. 10, a new declaration about the health status of the Insured must be filled out, as well as other data and information, including medical and financial information that the Insurer may require for assessment of the insurance and financial risk. The Policy holder must fill out/present the respective documents required by the applicable law.

(2) Group contracts for more than 30 individuals are concluded at the expense of the Policy holder on the grounds of an insurance application template of the Insurer and on the basis of a list of names, in which the Policy holder explicitly identifies and specifies the insured persons/employees. In this case, the Policy holder may specify different insurance amounts for different groups of insured persons.

(3) Where the Policy holder is a legal entity and the number of the insured persons is less than 10% of the total number of its employees, but not less than 30 (thirty) persons, the insurance is concluded on the basis of a declaration, template of the Insurer, about the health status signed personally by the Insured persons.

(4) For a group of up to 30 (thirty) persons inclusive, the insurance is concluded after filling out the Insurer's template of declaration for health status, regardless of the insurance amount.

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

(6) Where the Policy holder, the Insured, their proxies or insurance brokers have deliberately disclosed incorrectly or have concealed a circumstance, under which, and if aware of 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.

(7) 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 6.

(8) Where an insurance event has occurred in the cases under paragraph 6 and paragraph 7, the Insurer may refuse to pay the insurance amount entirely or partially, only if the disclosed incorrectly 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.

(9) 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 may terminate the insurance with a written notice to the other party. In this 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 paid premium to the premium that had to be paid according to the actual insurance risk.

(10) During the term of the insurance contract, the Insured is obliged to disclose to the Insurer all newly arising circumstances about which the Insurer has put written questions. The disclosure 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 12. (1) The Policy holder is entitled to designate one or more beneficiaries who are specified in the Special Terms and Conditions along with their rights. Beneficiary may be the Policy holder, or the Insured, or another individual, or a legal entity specified by the Policy holder. In case of many beneficiaries, their rights are equal, unless expressly agreed otherwise.

(2) If the third beneficiary dies before the Insured, and if no other beneficiaries are specified in the insurance contract, upon the occurrence of the insurance event, the insurance amount is paid to the Insured or to his/her heirs, unless the insurance contract provides otherwise. Sentence one applies also in case of termination of a legal entity, where such legal entity is the beneficiary.

Article 13. (1) The contract enters into force on the date specified in the Special Terms and Conditions as the beginning of the insurance coverage, provided that the insurance premium or the first instalment thereof is paid and the Insured is alive and capable at that time.

(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 broker of the Insurer against signature and payment of the first premium. 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 day specified by the insurance contract as the end of the period.

Article 14. (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 changes in the insurance contract:
– Any change of the periodicity of the instalments of the insurance premium must be requested no earlier than 2 (two) months and no later than 1 (one) month before the next anniversary of the contract. If accepted by the Insurer, such change will enter into force from the beginning of the successive insurance year. The new periodicity must correspond to the one of the basic insurance, excluding the case of a single premium basic insurance.

2. If accepted by the Insurer, changes that may be required at any time during the contract term enter into force on the date of their approval and their entry into the contract administration system by the Insurer:

2.1. change of the beneficiaries – where the Policy holder the Insured are different subjects, the right to such change of the contract belongs to the Policy holder, subject to the explicit consent of the Insured;

2.2. change of the Policy holder, which is possible only after the Insurer has received the explicit written consent of the previous Policy holder, the new Policy holder, and the Insured. Consent of the previous Policy holder is not required if the change is due to death of the previous Policy holder;

2.3. change of the address of residence of the Policy holder (physical person) or the Insured, or of the management address of the Policy holder (legal entity), respectively.

(3) The request for changes under paragraph 2 is filed by application filled in by the Policy holder according to the template of the Insurer, while the changes are made by signing an addendum to the contract by the parties thereto. The Policy holder must fill out/present the respective documents required by the applicable law.

(4) For each change under paragraph 2, a fee of EUR 10 (ten) is owed to the Insurer.

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

(6) 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 of the terms and conditions for providing insurance protection under the insurance contract, the Insurer may offer the Policy holder changes of the tariffs and the terms and conditions of the policy. The change becomes effective upon consent of the Policy holder. If no consent is given in writing and explicitly within one month from the date of receipt of the request, the insurance contract is terminated upon the expiration of this period.

(7) Under the insurance policy, the insurance period cannot be reduced and no changes can be made of Insured persons, except for group insurance contracts, as well as of any other elements of the policy, except those specified in paragraph 2.

(8) For each change of parameters of the basic insurance contract for „Life“ insurance, term „Life“ insurance and „Life“ insurance linked to investment fund, the Insurer may propose change of the parameters of such supplementary insurance. If the Policy holder does not accept the proposal, the contract may be terminated.

Article 15. (1) The insurance contract is terminated upon the expiration of its period, upon the death of the Insured, or in other cases provided for by the Insurance Code or by the contract.

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

1. with 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 the procedure of Article 14, paragraph 5;

4. in case of delayed payment of the premium or any instalment thereof, or if less than the due amount is paid;

5. with mutual written agreement between the parties.

(3) Upon the termination of the basic insurance contract for „Life“ insurance or its transformation into a contract with reduced insurance amount, as well as upon the termination of the basic insurance contract for „Life“ insurance linked to investment fund, the supplementary insurance contract for „Critical illnesses“ insurance is terminated automatically from the date of termination or transformation of the basic insurance contract.

SECTION VI. INSURANCE PREMIUM

Article 16. (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 term, the insurance amount, the age of the Insured (in case of group contracts, on the calculated or estimated average age of the insured persons) and the information disclosed in the declaration for health status, the occupation and the activities of the Insured.

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

(3) The possible payment methods are specified in the Special Terms and Conditions.

Article 17. (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 instalments as specified in the contract. If the annual premium is paid in instalments (i.e. in equal instalments more frequent than annual), the one-year series of deferred premium instalments becomes due at the beginning of the insurance year, while each successive instalment becomes due on the date specified in the Special Terms and Conditions.

(2) The payment method and the currency of the insurance premium correspond to these of the basic contract.

(3) The insurance premium is paid as follows:

1. the first annual premium, or its first instalment thereof in case of deferred payment, is paid

no later than the date of filing of the insurance application at the Insurer, while the grounds for the payment are the number of the insurance application, and the payment is effected by the methods specified in the insurance application;

2. the insurance premiums/instalments following the first one are paid no later than the first day of each one-year insurance period or in instalments according to the due dates and payment methods specified in the Special Terms and Conditions.

3. in BGN or in the respective contract currency equivalent determined by the Bulgarian National Bank exchange rate on the date of payment.

(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 18. As a date of payment of the insurance premium, the value date of the due amount in the Insurer's bank account is considered.

(2) The insurance premium under this insurance is paid simultaneously with the insurance premium under the basic insurance contract. Exception is admissible for basic insurances with single premiums.

(3) In case of non-payment of the premium within the term agreed in the Special Terms and Conditions, the Insurer may terminate the contract.

(4) The Insurer may exercise the right under the previous paragraph 3 no earlier than one month after the date, on which the Policy holder has received the written notification by the Insurer.

(5) If the due instalment is paid after the due date specified in the contract, but before the expiration of the notification period under paragraph 4, the insurance remains in force under the conditions upon its conclusion.

SECTION VII. INTERACTION IN CASE OF AN INSURANCE EVENT

Article 19. (1) Evidence of the occurrence of any insurance event covered by the contract must be provided and certified by:

1. licensed medical practitioners-specialists who cannot be the Policy holder, the Insured, beneficiaries or partners/spouses, relatives, respectively;

2. tests confirming the occurrence of a critical illness covered by these terms and conditions, including but not limited to clinical examinations, X-ray, radiological, histological and laboratory data, as well as

3. if the insurance event requires a surgical procedure, such surgical procedure must be the usual treatment for the condition and must be medically necessary.

(2) The occurrence of the insurance event is certified by the trusted medical consultants of the Insurer. The Insurer reserves the right to require medical examinations and other necessary tests of the Insured that confirm the occurrence of the critical illness.

(3) Upon the occurrence of an insurance event, the beneficiary is obliged to inform the Insurer in writing and submit the following documents (originals or certified copies) related to the confirmation of the event.

1. application for payment of an insurance amount – template;

2. Special Terms and conditions;

3. copy of the identity document of the beneficiary;

4. expert decision of the TEMC, where the person is certified as a person with permanently reduced or lost working capacity related to the critical illness;

5. traffic accident act or report/accident report, if the critical illness is due to an accident;

6. chemical expertise for the presence of alcohol in the blood;

7. enforced conviction;

8. detailed and complete medical documentation about the cause, onset, type and progress of the illness, all reports and tests by physicians and medical facilities that have examined and treated or continue to treat the Insured, epicrises and all other documents from hospitals, rehabilitation centres or medical facilities where examinations, consultations or treatments were conducted before and during the illness;

9. Insurer's template filled out by the treating specialist confirming the critical illness;

10. bank account certificate of the beneficiary.

(4) Where the confirmation and treatment of the critical illness is performed outside the Republic of Bulgaria, the template confirming the illness is filled out by a trusted specialist appointed by the Insurer. All documents are submitted in Bulgarian, translated by a sworn translator.

(5) The Insurer may require other documents to assess the insurance claim and decide on the payment of the insurance amount.

(6) 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.

(7) 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.

SECTION VIII. INSURANCE LIABILITY LIMIT

Article 20. (1) The due insurance amount in case of occurrence of a risk covered by the policy is specified in the Special Terms and Conditions.

Article 21. (1) The insurance payment is made 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 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 claim, the Insurer informs the Insured/the beneficiaries under the insurance contract about such further evidence no later than 45 (forty-five) days after the submission of the evidence specified 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 filing.

(4) The insurance payment is made to the personal bank account in the Republic of Bulgaria specified by the beneficiary. If the beneficiary wishes payment to an account outside the Republic of Bulgaria, the costs of the transfer are at the expense of the beneficiary.

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

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

(7) In case of death of the insured, the due insurance amount is paid to the legal heirs of the Insured specified in the certificate of heirs, while the total amount is divided equally between them.

(8) Where the insurance event has occurred before the full payment of the insurance premium, the Insurer may offset the unpaid premium against the due insurance payment.

Article 22. (1) The total amount of all payments under insurance claims during the entire insurance coverage period cannot exceed the insurance amount specified in the contract.

SECTION IX. OTHER PROVISIONS

Article 23. (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 by the Policy holder 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 24. (1) 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 25. (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, terms and conditions for processing personal data is published on the website of the Insurer at: 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, as well as in conjunction 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 26. (1) 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 contract, the Insurer does not provide coverage, is not liable to pay 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.

Article 27. The rights and the obligations under the insurance contract concluded under these General Terms and Conditions are lapsed with the expiration of 5 (five) years from the date of occurrence of the insurance event. The interest receivables on the insurance payment, if any, are lapsed with the expiration of the 3 (three) year limitation period.

Article 28. No compulsory sequestration of the insurance amount is allowed.

Article 29. 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 30. 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 31. (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 this, or unless the parties agree otherwise.

SECTION X. FINAL PROVISIONS

§1. These General Terms and Conditions have been adopted by decision of the Management Board of Joint Stock Insurance Company (ZAD) Bulstrad Life AD under MoM No. 19 of 19.04.2006.

§2. These General Terms and Conditions have been amended and supplemented by a decision under MoM No. 317/09.09.2021 of the Management Board of SOLELY OWNED JOINT STOCK INSURANCE COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE, in force from 01.11.2021.

§3. These General Terms and Conditions have been amended and supplemented by a decision under MoM No. 338/09.06.2022 of the Management Board of SOLELY OWNED JOINT STOCK INSURANCE COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE.

§4. These General Terms and Conditions have been amended and supplemented by a decision under MoM No. 381/21.12.2023 of the Management Board of SOLELY OWNED JOINT STOCK INSURANCE COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE.

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: Signature:
(name, surname, family name)

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