GENERAL TERMS AND CONDITIONS
VOLUNTARY HEALTH INSURANCE

INTRODUCTORY PROVISIONS

Article 1
General Terms and Conditions of the Voluntary Health Insurance (hereinafter: the General Conditions) shall be the integral part of Contract on Voluntary Health Insurance concluded between the Policyholder and Dunav Insurance Company a.d.o. The General Conditions hereof shall regulate the rights and obligations of the Policyholder, the Insured and the Insurer in accordance with the type of concluded Contract on Voluntary Health Insurance (Contract on parallel, supplementary or private health insurance, or Contract stipulating the combination of parallel, supplementary, i.e. private voluntary health insurance).

DEFINITIONS

Article 2
Particular terms in the General Conditions hereof shall mean:
1) Insurance Provider (hereinafter: the Insurer) is Dunav Insurance Company a.d.o.
2) Insured is a natural person who has concluded an Insurance Contract, or on whose behalf, based on his consent, an Insurance Contract has been concluded with the Insurer, and is exercising the rights stipulated under the Insurance Contract.
3) Policyholder of a Voluntary Health Insurance (hereinafter: the Policyholder) is any entity or natural person as well as any other legal entity that in the name and on behalf of the Insured, i.e. in his own name and on behalf of the Insured concludes Contract on Voluntary Health Insurance (hereinafter: Insurance Contract) with the Insurer and is obliged to effect payment of insurance premium from his own funds or by debiting the account of the Insured. The Policyholder may at the same time be the Insured.
4) Application is a written offer of the Policyholder for conclusion of Insurance Contract, sent to the Insurer.
5) Insurance policy (hereinafter: the Policy) is a document on Insurance Contract concluded with the Insurer;
6) Insurance premium (hereinafter: the Premium) is amount of money which the Insured i.e. the Policyholder is obliged to pay to the Insurer, in accordance with the Insurance Contract.
7) Group insurance is a Voluntary Health Insurance that the Policyholder concludes with the Insurer he has selected pursuant to the law, for which the Policyholder and the insurer may conclude Insurance Contact.
8) Medical services are services provided in health institutions and other forms of health services (hereinafter: private practice), according to the law regulating health protection, with the aim to provide health protection, i.e. to implement measures for preserving and improving health of people, prevention, control and timely detection of illnesses, injuries and other health impairments, treatments and rehabilitation, including also medical services of traditional medicine, that are safe, quality and efficient.
9) Health institution is a legal entity carrying out healthcare activities that has been granted a license by the Ministry in charge of health affairs (hereinafter: the Ministry) to carry out healthcare activities, pursuant to the law regulating health protection and the regulations enacted for enforcement of such law, with which the Insurer has concluded the Business Cooperation Contract.
10) Medical service providers are health institutions, private practice and other medical service providers;
11) Private practice is a different form of health service where particular healthcare activities are being carried out and that has been granted a license by the Ministry to carry out particular healthcare activities pursuant to the law regulating health protection and the regulations enacted for enforcement of such law.
12) Other medical service providers are other legal entities or natural persons that carry out particular healthcare activities, i.e. provide medical-technical aids, and that have been granted a license by a competent authority for carrying out such activities, in accordance with the law.
13) Medicine is a product that has been granted a marketing authorization in the Republic of Serbia as well as a product that has not been granted a marketing authorization in the Republic of Serbia and is imported under the authorization of Medicines and Medical Devices Agency of Serbia, in accordance with the law regulating the medicines sector.
14) Medical-technical aids are medical devices intended for functional and aesthetic replacement of lost body parts, i.e. for providing support, preventing occurrence of deformities and correction of present deformities and facilitating of basic vital functions performance.
15) Implant is a medical device that is surgically built in human organism.
16) Pecuniary compensations are compensations that the Insurer pays to the Insured in case of a loss of earnings i.e. salary or other income due to temporary
work incapacity, compensation for transport costs relating to the use of medical services, as well as other pecuniary compensations relating to exercising rights under Voluntary Health Insurance.

17) Sum insured is agreed maximum amount of Insurer’s liability stated in the policy.

18) Insured event is an occurrence based on which the Insurer is obliged to indemnify the Insured or do whatsoever according to the law or Insurance Contract.

19) Waiting period is a period at the beginning of a contracted insurance period during which the Insurer is not obliged to pay insurance indemnity regardless of the occurrence of insured event during such period, stipulated under the Special Terms and Conditions of the Insurer.

20) Document on Voluntary Health Insurance (hereinafter: the Document) is a document that the Insurer issues to the Insured, based on which the Insured proves the status of Insured person under Voluntary Health Insurance and exercises rights thereunder.

21) Special terms and conditions of Voluntary Health Insurance (hereinafter: Special Conditions) are the Insurer’s terms and conditions regulating rights and obligations of contractual parties for a particular type of Voluntary Health Insurance, which are an integral part of Insurance Contract and have to be handed over to the Insured.

TYPES OF VOLUNTARY HEALTH INSURANCE

Article 3

Voluntary Health Insurance shall cover the costs for the type, contents, scope and standard of rights that are contracted with the Insurer.

Parallel Health Insurance shall mean insurance for covering the costs of health protection that are incurred when the Insured is a beneficiary of health protection included into mandatory health insurance, according to a method and procedure other than the method and procedure of exercising rights under mandatory health insurance prescribed by the law regulating health insurance and the regulations enacted for the enforcement of such law.

Supplementary Health Insurance shall mean insurance for covering the costs of medical services, medicines, medical-technical aids and implants, i.e. pecuniary compensations not covered under the rights of mandatory health insurance, i.e. insurance to bigger contents, scope and standard of rights, and the amount of pecuniary compensations higher than the ones covered under mandatory health insurance.

Private Health Insurance shall mean insurance of persons not covered under mandatory health insurance or not included into mandatory health insurance, for covering the costs for the type, contents, scope and standard of rights concluded with the Insurer.

ELIGIBILITY

Article 4

The person shall be eligible for parallel i.e. supplementary voluntary health insurance if he is covered under mandatory health insurance in the Republic of Serbia, and expresses clear intention to conclude the contract with the Insurer on parallel i.e. supplementary voluntary health insurance, according to the General and Special Terms and Conditions.

The person shall be eligible for private voluntary health insurance when he is not covered under Voluntary Health Insurance, or included into mandatory health insurance, but expresses clear intention to conclude the Insurance Contract with the Insurer, according to the General Terms and Conditions hereof and Special Terms and Conditions for private voluntary health insurance.

Insured’s family members defined in the Special Terms and Conditions of the Insurer may be eligible, if specified in the Insurance Contract or on the list accompanying the Contract and if stipulated premium has been paid for them.

The person who, when submitting the application for the Insurance Contract conclusion, does not owe any outstanding stipulated premiums under previous contracts on Voluntary Health Insurance to the Insurer, shall be eligible for insurance.

CONCLUSION OF THE CONTRACT

Article 5

The Insurance Contract shall be concluded based on the previous written application that the Policyholder i.e. the Insured submits to the Insurer on Insurer’s form. When concluding group insurance contract, the Policyholder may submit single application which shall contain data on each and every person who wants to conclude insurance with the Insurer.

When concluding Insurance Contract, the Policyholder, i.e. the Insured shall be obliged to fulfill Questionnaire on Insured’s health condition and submit all other required documentation, upon the Insurer’s request.

Data from the Questionnaire cannot be the reason for insurance rejection. Based on the data from Questionnaire and other required documentation, the Insured persons shall be classified into different classes of hazard, according to the Special Terms and Conditions for insurance against abnormal risk.

Written application for conclusion of Insurance Contract shall be binding upon the Applicant (the Policyholder) for the period of 8 days from the day the Insurer received the application, if the Applicant has not defined shorter
period, and in case a medical check-up is needed, for the period of 30 days from the day the Insurer received the application.

If, within the period referred to in paragraph 6 of the Article hereof, the Insurer fails to reject the application that does not depart from his contract conditions, he shall be deemed to have accepted the application and that the Insurance Contract has been concluded as of the date of application receipt.

Should the Insurer accept the insurance application only under altered contract conditions, the Insurance Contract shall be deemed concluded as of the date the Applicant accepted such altered conditions.

It shall be deemed that the Applicant waived the application if he fails to accept the altered contract conditions within 8 days from the date he received registered notification from the Insurer.

By signing the application, the Insured i.e. the Policyholder shall confirm acceptance of the General and Special Terms and Conditions.

**POLICY AND DOCUMENT**

**Article 6**

The Insurer shall issue a policy to the Insured, i.e. the Policyholder as of the date of signing Insurance Contract.

The Insurer shall issue a policy to the Insured, and for group insurance he shall issue one policy to the Policyholder for all insured persons.

When issuing a policy, and not later than 60 days thereafter, the Insurer shall be obliged to issue a document to the Insured under such policy, based on which he shall prove the status of Insured person and exercise rights under Voluntary Health Insurance.

Rights under Voluntary Health Insurance shall be exercised based on the Document, and exceptionally based on the policy until the moment of obtaining the Document. As regards Insurance Contracts that are contracted for the period of 90 days, the Insured shall exercise his rights under Voluntary Health Insurance based on the policy. In case the Document has been lost, the rights under insurance shall be exercised based on the Policyholder’s certificate of insurance i.e. policy until the duplicate of such Document is issued.

Integral part of Group Insurance Contract shall be the list of Insured persons or extract from personnel records of the Policyholder for persons included into Voluntary Health Insurance. The Insurer shall issue the Document to any one Insured person from the list or Policyholder’s records, not later than 60 days from the date of policy issue.

As regards group insurance, the Insured shall exercise his rights under concluded Insurance Contract until the Document issue, based on the certificate on concluded insurance issued to him by the Policyholder.

**INCEPTION AND DURATION**

**Article 7**

Voluntary Health Insurance shall be concluded for a period not shorter than 12 months from the date of insurance inception, except when the status of Insured person under mandatory health insurance should last for a shorter period in accordance with the regulations under mandatory health insurance.

By way of exception, Voluntary Health Insurance during the Insured’s stay abroad, i.e. for covering costs of health protection services provided to him abroad, may last for a shorter period.

**Article 8**

The Insurance hereof shall come into effect at 24:00 hours on the date indicated in the Policy as the inception date of insurance, provided that the stipulated insurance premium has been paid by that date.

If the premium is paid after the date indicated in the Policy as the inception date, the Insurance shall come into effect at 24:00 hours on the date of payment of stipulated premium, if not agreed otherwise.

Insurance Contract shall terminate upon the expiry of 24:00 hours on the date indicated in the Policy as the termination date.

**Article 9**

The Insurance hereof shall terminate before the agreed period in the following events:

1. Death of the Insured – on the day of death;
2. Cancellation of Insurance Contract, pursuant to Articles 19 and 21 of the General Terms and Conditions hereof;

**Waiting Period**

**Article 10**

Waiting period can be stipulated in accordance with the Insurance Contract.

Waiting period is a period from coming into effect of an Insurance Contract to the moment of risk assumption in full by the Insurer.

Waiting period shall not apply for renewal of Insurance Contract.

**COMMENCEMENT AND TERMINATION OF INSURER’S OBLIGATIONS**

**Article 11**

Obligations of the Insurer, in terms of Insurance Contract, shall commence at 24:00 hours on the date indicated in the Policy as the inception date, provided
that the stipulated insurance premium has been paid by that date. If the premium is paid after the date indicated in the Policy as the inception date, the obligations of the Insurer shall commence at 24:00 hours on the date of payment of stipulated premium, if not agreed otherwise. Obligations of the Insurer shall terminate upon expiry of 24:00 hours on the date indicated in the Policy as the termination date of insurance. By way of exception from paragraph 3 of this Article, obligations of the Insurer shall terminate as stipulated under Articles 19, 20 and 21 of the General Terms and Conditions hereof.

RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED

Article 12
When exercising rights under the Insurance Contract, the Insured shall be obliged to submit evidence on concluded Insurance Contract. Evidence on concluded Insurance Contract is a policy until receiving the Document under Article 6 of the General Terms and Conditions hereof or a certificate of the Policyholder on the Insurer’s form. In addition to the evidence on insurance under paragraph 2 of this Article, the Insured is obliged to submit identification document (identification card, passport or other adequate document with a photograph). In case of loss of evidence on insurance under paragraph 2 of the Article hereof, the Insured shall be obliged to report such loss to the nearest organisational unit of the Insurer. Rights under the Insurance Contract cannot be assigned to other persons or inherited. Pecuniary compensations that are due for payment, and that have remained unpaid due to death of the Insured, can be inherited according to provisions of the law.

Article 13
The Policyholder i.e. the Insured shall be obliged to regularly pay due premium, within the deadlines stipulated under the Insurance Contract i.e. Policy. When concluding the Insurance Contract, the Policyholder i.e. the Insured shall be obliged to inform the Insurer on all circumstances important for risk assessment, and of which the Insured is or must have been familiar with. The Policyholder i.e. the Insured is obliged to give correct and complete answers to the questions stated in the Application form under Article 5 of these General Terms and Conditions and Questionnaire form on Insured’s health condition. When exercising rights under the Voluntary Health Insurance according to the chosen programme, the Policyholder i.e. the Insured shall be obliged to call the contact centre of the Insurer and provide necessary information from the Document, based on which the method and procedures of provision of medical services are determined, according to the agreed health insurance programme. While exercising rights under the Voluntary Health Insurance, the Policyholder i.e. the Insured submits a claim on the Insurer’s form under Article 18 of the Rules of Voluntary Health Insurance to the competent organisational unit of the Insurer.

INSURER’S SCOPE OF OBLIGATIONS

Article 14
The Insurer shall be obliged to enable the insureds under Voluntary Health Insurance to exercise rights stipulated under the Insurance Contract.

Article 15
If the right to compensation is a consequence of health condition incorrectly reported when concluding the Insurance Contract, the obligation of the Insurer shall be reduced proportionally to the difference between the paid premium and the premium that should have been paid according to the actual risk.

Article 16
Pursuant to the Insurance Contract i.e. Policy and Special Terms and Conditions, the Insurer shall be obliged to compensate to the provider of medical services or the Insured for costs or part of costs that have incurred when exercising the rights under the Voluntary Health Insurance, that is the amount of agreed pecuniary compensation within 14 days following the day of receiving the complete documentation based on which indisputable existance and scope of obligation can be determined.

Article 17
The Insurer shall not be obliged to pay insurance indemnity in the following cases:
1. If the Insured has provided false and incorrect data, that is, if he has concealed important circumstances that affect the conclusion of the Insurance Contract.
2. If neither the Policyholder i.e. the Insured nor any other person on behalf of him pays due premium within the agreed term;
3. In case of misuse of Policy i.e. Document;
4. If the scope of agreed medical services, the amount of costs and sum insured are exceeded;
5. If the claim is based on false data and false documentation.


**INSURANCE PREMIUM**

**Article 18**

The Insurance Contract i.e. the Policy stipulates the amount of premium and premium payment method. The Insurer cannot increase the stipulated amount of premium for insurance contracts concluded for a period of up to 12 months. By way of exception, for long-term insurance contracts premium can be changed upon expiry of 12 months from the day of conclusion of the Insurance Contract, that is, in every 12 months up to the expiry of the concluded Insurance Contract.

The Policyholder i.e. the Insured shall be obliged to regularly pay due premium to the Insurer, within deadlines stipulated under the Insurance Contract i.e. the Policy.

The Insurer shall be entitled to annual premium regardless of the agreed premium payment method (semi-annual, quarterly or monthly).

The Insurer shall be entitled to charge legal default interest against the Policyholder i.e. the Insured for each day of failure to meet the deadline for payment of due premium.

If premium is paid through a post office, it shall be deemed to have been paid at 24:00 hours on the day when payment had been effected at the post office, whereas if premium is paid through a bank, it shall be deemed to have been paid at 24:00 hours on the day when the bank received the order.

The Insurer shall be obliged to accept premium paid by any third party that holds legal interest to meet such obligation.

Payment of arrears of premium instalments always refers to the first outstanding premium instalment.

**TERMINATION OF INSURANCE CONTRACT**

**Article 19**

If neither the Policyholder i.e. the Insured nor any other person on his behalf pays the due premium up to the agreed term, the Insurer can cancel the Insurance Contract with the Policyholder i.e. the Insured upon expiry of 30 days from the day when the Policyholder i.e. the Insured received a written notice on due and outstanding premiums.

Upon expiry of the period under paragraph 1 of the Article hereof, the Insurer can unilaterally cancel the Insurance Contract without a notice period and institute an action for collection of due premiums with corresponding interest before the competent court.

**Article 20**

If the Insured has deliberately incorrectly reported or concealed some circumstances of such nature that the Insurer would not have concluded Insurance Contract under the same conditions if he had known the real situation, the Insurer may demand cancellation of the Insurance Contract.

**Article 21**

The Policyholder i.e. the Insurer may cancel the Insurance Contract in a way and within the deadlines stipulated under the Special Terms and Conditions.

**INSURANCE RENEWAL**

**Article 22**

When the Insured wishes to renew the Voluntary Health Insurance under other conditions or when the Policyholder is changed, the current Insurance Contract ceases to be valid and a new one is concluded without discontinuance of insurance.

The Insured shall be entitled to compensation under the terms of the Insurance Contract valid on the date of occurrence.

Renewal of insurance under paragraph 1 of the Article hereof shall be done on the basis of:

- A written request submitted not later than 30 days before the expiry of insurance period under the valid insurance contract

- An oral request submitted not later than 15 days before the expiry of insurance period under the valid insurance contract, based on which the Insurer at the same time makes out a written proposal for the Insured to sign.

**COMPLAINTS OF THE INSURED**

**Article 23**

The Insured who is dissatisfied with the claim decision may file a complaint against the Insurer. Complaints settlement procedure is regulated by the Special Terms and Conditions for particular type of voluntary health insurance, that is, a combination of parallel, supplementary i.e. private voluntary health insurance.

**DATA ON INSUREDS**

**Article 24**

The Policyholder and the Insured shall authorize the Insurer to collect, check, process, keep and use the personal data necessary for conclusion of insurance contract, and also for determination of rights to compensation, according to the law regulating the protection of personal data.

When concluding insurance contract the Insurer shall not ask for genetic data, that is, results of genetic testing for certain inherited diseases, neither of a person that has clear intention to conclude an insurance contract, nor of his relatives, regardless of the line and degree of kinship.
APPLICABLE LAW AND JURISDICTION

Article 25

Implementation, effect and interpretation of the Insurance Contract concluded under these General Terms and Conditions are subject to the law and jurisdiction of the Republic of Serbia.

Article 26

Aging of accounts receivable under the Insurance Contract shall be regulated by adequate provisions of the Law on Contracts and Torts.

Article 27

Provisions of the Law on Contracts and Torts and Regulations on Voluntary Health Insurance, as well as provisions of other statutory regulations of the Republic of Serbia that regulate the insurance industry shall apply to the issues not regulated by the General Terms and Conditions hereof.

APPLICATION OF THE GENERAL TERMS AND CONDITIONS

Article 28

If the Insurer makes any amendments to the General Terms and Conditions, he shall be obliged to inform in writing, or any other suitable way (daily newspapers, radio, television, Internet web site of the Insurer, etc.) the Policyholder i.e. the Insured with whom he has concluded a long-term insurance contract. In case of amendments to the General Terms and Conditions during the insurance period of long-term insurance contract, application of new Terms and Conditions may be agreed starting with the following insurance year, for which a written approval of the Insured is necessary.

Article 29

The General Terms and Conditions hereof shall be posted on the Internet web site of the Insurer. These General Terms and Conditions shall take effect on the day following the day of their publication in the Company Bulletin and shall apply as of January 1st 2010.