VOLUNTARY HEALTH INSURANCE
GENERAL TERMS AND CONDITIONS

INTRODUCTORY PROVISIONS
Article 1

(1) General Terms and Conditions of the Voluntary Health Insurance (hereinafter: the General Terms and Conditions) shall form an integral part of Contract on Voluntary Health Insurance concluded by and between the Policyholder under the Voluntary Health Insurance and Dunav Insurance Company a.d.o.
(2) The General Terms and 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 a contract stipulating the combination of parallel, supplementary and/or private Voluntary Health Insurance).

DEFINITIONS
Article 2

(1) Particular terms in the General Terms and Conditions hereof shall mean the following:
1) Insurance Provider (hereinafter: the Insurer) is Dunav Insurance Company a.d.o.
2) Insured is a natural person concluding the Voluntary Health Insurance Contract or on whose behalf, following his consent (with the exception of group insurance) the Voluntary Health Insurance Contract has been concluded with the Insurer and who is exercising the rights stipulated under the Voluntary Health Insurance Contract in case of the insured occurrence;
3) Policyholder under a Voluntary Health Insurance (hereinafter: the Policyholder) is any legal entity or a natural person as well as any other legal person 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 and the Insured may be the same person.
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 and/or the Policyholder pays to the Insurer in accordance with the Insurance Contract.
7) Family members are spouses or common-law partners and children of the Insured if they are listed in the Policy and provided the insurance premium has been paid for them. Children are deemed so if born in or out of a wedlock, adopted children, stepchildren and children taken for support until the full age of 18 or up to the full age of 26 if they are attending a regular school;
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 and/or 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) Authorized healthcare worker and healthcare associate are persons who, directly as a profession, perform healthcare activities in health institutions or private practice, under the conditions prescribed by the law regulating health care;
10) 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;
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 and/or provide for medical and technical aids and have been granted a license by a competent authority for carrying out such activities, in accordance with the law;
13) Medical service providers is a joint title for health institutions, private practice and other medical service providers who have been granted a licence by a Ministry in charge of health affairs to carry out to carry out particular healthcare activities, pursuant to the law regulating health protection and the regulations enacted for enforcement of such law, with whom the Insurer has concluded a contract for the provision of healthcare services (Network of healthcare service providers). The insurer shall classify the healthcare service providers into the appropriate lists of Network of healthcare service providers according to the standard of services and other relevant criteria;
14) Network of healthcare service providers are all healthcare service providers having, within a period of the insurance contract, signed with the Insurer an effective contract on the provision of healthcare services and where the Insured is using a services agreed under the insurance Policy as stipulated under the General and Special Terms and Conditions;
15) Medical Call Centre is an assistance company of the Insurer that operates 24 hours a day and allows the Insured the contact with medically educated persons for providing medical assistance in the insurance realization in the manner provided for under Special Terms and Conditions;
16) 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;
17) Medical and 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;
18) Implant is a medical device that is surgically built in human organism;
19) 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, reimbursement for transport costs relating to the use of medical services, as well as other pecuniary compensations relating to exercising rights under Voluntary Health Insurance.
20) Sum insured is agreed maximum amount of Insurer’s liability stated in the Policy;
21) Insured event is an occurrence of circumstances based on which the Insurer is obliged to indemnify the Insured or do whatsoever under the law or Insurance Contract;
22) Insurance cover is a coverage of reasonable medical expenses pursuant to the Special Terms and Conditions, agreed under the Insurance Contract;
23) Waiting period is agreed time period at the beginning of a contracted insurance period during which the Policyholder is obliged to pay the insurance premium and the Insurer is not obliged to pay insurance indemnity regardless of the occurrence of insured event stipulated under the Special Terms and Conditions of the Insurer during such period;
24) 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 the Insured person under Voluntary Health Insurance and exercises rights thereunder;
25) Special Terms and Conditions of Voluntary Health Insurance (hereinafter: Special Terms and 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 Policyholder.

TYPES OF VOLUNTARY HEALTH INSURANCE
Article 3

(1) Voluntary Health Insurance shall cover the costs for the type of Voluntary Health Insurance stipulated under the Regulations of the Voluntary Health Insurance, for the contents, scope and standard of the rights that are contracted with the Insurer.

ELIGIBILITY
Article 4

(1) Any person shall be eligible for parallel i.e. supplementary voluntary health insurance if such person has a status of Insured under mandatory health insurance in the Republic of Serbia and expresses clear intent to conclude the contract with the Insurer on parallel i.e. supplementary voluntary health insurance according to the General and Special Terms and Conditions.
(2) Any person shall be eligible for private voluntary health insurance when such person 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.
(3) Insured’s family members defined in the Special Terms and Conditions of the Insurer may acquire a status of the Insured person if specified in the Insurance Contract or on the Schedule attached to the Contract and provided stipulated premium has been paid for them.
(4) Any 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 CONTRACT
Article 5

(1) The Insurance Contract shall be concluded based on the previous written Application submitted by the Policyholder and/or the Insured.
(2) When concluding a group insurance contract, the Policyholder may submit a single Application that includes data on all the persons for whom the Policyholder wishes to take out the coverage with the Insurer.
(3) When concluding Insurance Contract, the Policyholder and/or the Insured shall be obliged to inform the Insurer on all circumstances relevant for risk assessment, with which the Policyholder/Insured is or must have been familiar.
(4) When contracting insurance, the Insured shall, upon the Insurer’s request, fill in the Questionnaire on his health condition that is an integral part of the Application, undergo medical examination with an authorized healthcare worker/associate and submit all other required documentation, with a view of establishing the risk.
(5) Data from the Questionnaire cannot be the reason for denial of coverage. Based on the data from Questionnaire and other required documentation, the Insured persons are classified into different classes of hazard, except with group insurance.

(6) Written Application for conclusion of the 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.
(7) If, within the period referred to in paragraph 6 of the Article hereof, the Insurer fails to deny the Application that does not depart from the Insurer's contract conditions, he shall be deemed to have accepted the Application and the Insurance Contract shall be deemed concluded as of the date of the Application receipt.
(8) 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.
(9) 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 the notification from the Insurer and/or in case he fails to submit the results of performed medical examination with an authorized healthcare worker/associate within 30 days following the date of receipt of the written request of the Insurer for performance of medical examination.
(10) By signing the Application, the Insured and/or Policyholder shall confirm the acceptance of the General and Special Terms and Conditions.
(11) If, during the period from the submission of the Application to the conclusion of the Insurance Contract, there is an increase in the Insured health risk, the Insured and/or the insurance applicant shall be obliged to notify the Insurer immediately upon gaining knowledge of these facts. Increased Insured health risks shall be deemed to include all diseases and/or illnesses, changes of occupation, insured person injuries, practising sports or travel into crisis areas, tropical areas or on expeditions as well as other changes that increase the health risk of the Insured.
(12) If, in the case of a general check-up or other medical examination, when using the services covered under the Insurance Contract, it is established that, at the time of the Insurance Contract conclusion, the Insured was suffering from a disease he did not declare when submitting the Application, the Insurer may propose insurance under the altered conditions.
(13) If the Applicant does not agree to the altered conditions within 8 days from the receipt of the notice with the insurance proposal at the altered conditions of the Insurer, the Contract shall be deemed terminated upon expiry of this period. In the event of termination of the Contract, the Insurer is entitled to the entire amount of the premium due.
(14) All documents that are delivered to the Insurer by the Applicant prior to the Policy issuance shall be deemed an integral part of the Application. The Application shall form an integral part of the Insurance Contract.

POLICY AND DOCUMENT
Article 6

(1) The Insurer shall issue a Policy to the Insured and/or the Policyholder as of the date of signing the Insurance Contract.
(2) 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.
(3) When issuing a Policy, and not later than 60 days thereafter, the Insurer shall be obliged to issue a Document to the Insured, based on which the Insured shall prove his status and exercise the rights under Voluntary Health Insurance.
(4) The 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 insurance Policy until the duplicate of the Document is issued.
(5) Integral part of Group Insurance Contract shall be the Schedule 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 from the Schedule or Policyholder's records, not later than 60 days from the date of Policy issue.

INCEPTION AND DURATION OF INSURANCE
Article 7

(1) 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 insurance lasts for a shorter period in accordance with the mandatory health insurance regulations.
(2) By way of exception, Voluntary Health Insurance that is contracted as private insurance and 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

(1) 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 such date.
(2) 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.
(3) Insurance Contract shall terminate upon the expiry of 24:00 hours on the date indicated in the Policy as the insurance termination date.

TERMINATION OF INSURANCE CONTRACT
Article 9

(1) 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 the Article 19 of the General Terms and Conditions hereof;
3. Annulment of the Insurance Contract, pursuant to Article 20 of the General Terms and Conditions hereof.

Waiting Period
Article 10

(1) Waiting period can be stipulated in accordance with the Insurance Contract.
(2) Waiting period is a period from coming into effect of an Insurance Contract to the moment of risk assumption in full by the Insurer.
(3) Waiting period shall apply starting from the inception of insurance defined in the Policy, provided the first agreed due premium is paid before that date.
(4) If due premium is not paid prior to insurance inception, the waiting period shall run as from 24.00 hours of the date when the first agreed premium is paid.
(5) The waiting period shall not apply for renewal of Insurance Contract, unless otherwise specified in the Contract.
(6) Provisions of paragraph 5 of the Article hereof shall apply only for the Insured who have acquired such status under a previous Policy and/or Insurance Contract and/or for whom the waiting period has already expired during the period of the previous Policy. If the waiting period has not fully expired during the period of the previous Policy, the remaining period of the total waiting period shall be transferred to the next insurance period under the new Policy.

(7) For particular insurance coverage, the Insurer may also stipulate other waiting period, in accordance with the Special Terms and Conditions of the Insurer.

INCEPTION AND TERMINATION OF INSURER'S LIABILITY
Article 11

(1) Liability of the Insurer under concluded Insurance Contract shall commence at 24:00 hours on the date indicated in the Policy as the insurance inception date, if the stipulated insurance premium has been paid by that date.
(2) If the premium is paid after the date indicated in the Policy as the insurance 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, after expiry of the waiting period pursuant to the Article 10 of the General Terms and Conditions hereof.
(3) The obligations of the Insurer shall terminate upon expiry of 24:00 hours on the date indicated in the Policy as the insurance expiry date.

RIGHTS AND OBLIGATIONS OF POLICYHOLDER AND INSURED
Article 12

(1) When exercising rights under the Insurance Contract, the Insured shall be obliged to submit evidence on concluded Insurance Contract.
(2) Evidence on concluded Insurance Contract is a Policy and/or a Document.
(3) In addition to the evidence on insurance, the Insured is obliged to submit an identification document with a photograph.
(4) In case of loss of evidence on concluded Insurance Contract, the Insured shall be obliged to report such loss to the Insurer.
(5) Rights under the Insurance Contract cannot be assigned to third parties 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

(1) When concluding the Insurance Contract, the Policyholder and/or the Insured shall be obliged to inform the Insurer on all circumstances relevant for the risk assessment, which are known nor must have been known to him.
(2) The Policyholder and/or the Insured is obliged to give correct and complete answers to the questions stated in the Application form and Questionnaire form on Insured's health condition.
(3) The Policyholder and/or Insured shall submit to the Insurer all documentation necessary for establishing the grounds, scope and amount of Insurer's obligation.
(4) When exercising rights under the Voluntary Health Insurance, the Policyholder shall undertake to primarily call the Medical Call Centre of the Insurer and provide necessary information from the Document required to determine the method and procedures of provision of medical services, according to the agreed insurance coverage.
(5) By way of exception and if agreed, while exercising rights under the Voluntary Health Insurance, the Policyholder and/or Insured shall submit a claim for indemnity filled in on the Insurer's form to the competent organisational unit of the Insurer.
(6) The Policyholder shall undertake to inform the Insurer on any change in the status of the Insured under the Voluntary Health Insurance within the insurance contract period and to deliver the Document for the persons who have lost the capacity of the Insured prior to the expiry of the Insurance Contract.

SCOPE OF INSURER'S LIABILITY
Article 14

(1) The Insurer shall be obliged to enable the Insured under Voluntary Health Insurance to exercise rights stipulated under the Insurance Contract.

Article 15

(1) If the right to indemnity is a consequence of health condition incorrectly reported when concluding the Insurance Contract, the liability of the Insurer shall be reduced

proportionally to the balance between the paid premium and the premium that should have been paid according to the actual risk.

Article 16

(1) Pursuant to the Insurance Contract and/or Policy and Special Terms and Conditions, the Insurer shall be obliged to reimburse 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 existence and scope of obligation can be determined.
(2) The Insurer shall be entitled to ask for the additional explanation or additional documentation from the Insured, Policyholder or any other legal entity or individual, so as the relevant circumstances regarding the notified insured event can be determined.
(3) The Insurer shall be entitled to refer the Insured to a medical check-up or additional medical examination to determine the necessary facts regarding the notified insured event. The costs of such examination shall be borne by the Insurer himself.
(4) If the Insured intentionally acquires unlawful material gain for himself or for any other legal entity or natural person, misleads the Insurer, or keeps the Insurer mislead, by false statement or concealment of facts, inducing the Insurer to take or fail to take particular actions to his own or to the detriment of a third party's property, the Insurer may file a criminal charges against such Insured.

Article 17

(1) 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 nor the Insured, nor any third party acting on their behalf, pays due premium within the agreed term;
3. In case of misuse of a 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

(1) The Insurance Contract and/or 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 term of concluded Insurance Contract.
(2) The Policyholder and/or the Insured shall be obliged to regularly pay due premium to the Insurer, within deadlines stipulated under the Insurance Contract i.e. the Policy.
(3) The Insurer shall be entitled to the annual premium regardless of the agreed premium payment method (semi-annual, quarterly or monthly).
(4) The Insurer shall be entitled to charge legal default interest against the Policyholder i.e. the Insured for each day of overtime after the expiry of the deadline for payment of due premium.
(5) If a premium is paid through a post office, it shall be deemed 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 paid at 24:00 hours on the day when the bank received the order.
(6) The Insurer shall be obliged to accept the premium paid by any third party that holds legal interest to meet such obligation.
(7) Payment of outstanding premium instalment always refers to the first outstanding premium instalment.

CANCELLATION OF INSURANCE CONTRACT
Article 19

(1) If neither the Policyholder i.e. the Insured nor any third party on his behalf pays the due premium up to the agreed term, the Insurer may 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 has received a written notice on due and outstanding premiums.
(2) 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 accrued interest before the competent court.
(3) The Policyholder and/or Insurer may terminate the Insurance Contract in such a manner and within the terms stipulated under the Special Terms and Conditions hereof.

ANNULMENT OF INSURANCE CONTRACT
Article 20

(1) If the Insured has deliberately incorrectly reported or concealed a particular circumstance of such nature that the Insurer would not have concluded Insurance Contract under the same conditions if he had known the actual situation, the Insurer may demand annulment of the Insurance Contract.

INSURANCE RENEWAL
Article 21

(1) When the Insured wishes to renew the Voluntary Health Insurance under different conditions or when the Policyholder is changed, the current Insurance Contract shall cease to be valid and a new one shall be concluded without discontinuance of insurance.
(2) The Insured shall be entitled to compensation under the terms and conditions of the Insurance Contract valid on the date of insured occurrence.

COMPLAINT OF THE INSURED
Article 22

(1) The Insured who is dissatisfied with the claim decision may file a complaint against the Insurer.
(2) The complaints settlement procedure is regulated under 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 INSURED
Article 23

(1) The Policyholder and Insured shall authorize the Insurer to collect, check, process, keep and use the personal data necessary for conclusion of Insurance Contract, and also for establishment of the rights to indemnity according to the law regulating the protection of personal data.
(2) The Insurer shall be obliged to keep the data under paragraph 1 of this Article as trade secret, pursuant to the law.
(3) When concluding the 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 24

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

Article 25
(1) Aging of accounts receivable under the Insurance Contract shall be regulated by adequate provisions of the Law on Contracts and Torts.

SUBROGATION
Article 26

(1) The rights of the Policyholder or Insured against any third party shall be assigned to the Insurer to the extent of obligation paid out by the Insurer, without obtaining a special consent of the Insured.

(2) For the purpose of exercising the right of recourse under the paragraph 1 of the Article hereof, the Insured shall be obliged to provide the Insurer with all the evidence that the Insurer requests from him and which are related to the claim for indemnity.
The costs of obtaining this evidence shall be borne by the Insurer
.

(3) If the Policyholder or the Insured receives indemnity from a third party responsible for the damage, the Insurer shall be entitled to deduct this amount from the indemnity to be paid to the Insured based on the insurance Policy.

APPLICATION OF THE GENERAL TERMS AND CONDITIONS
Article 27

(1) 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.
(2) 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.

TRANSITORY AND FINAL PROVISINS
Article 28

(1) The issues not regulated under the General Terms and Conditions hereof shall be governed by the provisions of Law on Contracts and Torts, Provision on the Voluntary Health Insurance as well as the clauses of other legal regulations of the Republic of Serbia which govern the insurance industry.

Article 29

(1) The General Terms and Conditions hereof shall be posted on the Internet web site of the Insurer.
(2) The validity of the General Terms and Conditions of Voluntary Health Insurance (Company Journal no. 42/09) shall terminate upon coming into force of the Insurance Terms and Conditions hereof.
(3) The General Terms and Conditions hereof shall become effective as of the date of their adoption.

THIS VERSION OF THE TERMS AND CONDITIONS SHALL APPLY AS OF 26TH DECEMBER 2018.