VOLUNTARY HEALTH INSURANCE
GENERAL TERMS AND CONDITIONS

Introductory Provisions
Article 1

(1) General Terms and Conditions of Voluntary health insurance (hereinafter: the General Terms and Conditions) shall regulate the implementation of voluntary health insurance with Dunav Insurance Company pursuant to the provisions of the Law on Insurance and Law on Health Insurance, namely:

1. Conditions and method of organizing and effecting voluntary health insurance;
2. Types of voluntary health insurance cover provided by the Insurer;
3. Conditions for concluding voluntary health insurance contracts with the voluntary health insurance Insured / Policyholder;
4. Conditions for termination of voluntary health insurance contract;
5. Conditions for concluding voluntary health insurance for family members of the voluntary health insurance/group insurance Policyholder;
6. The rights and duties of the Insured/Policyholder under the voluntary health insurance;
7. The rights and duties of the Insurer;
8. Period of voluntary health insurance;
9. General provisions on insurance premium;
10. Other Terms and Conditions relevant for the organization and effecting of voluntary health insurance.

Definitions
Article 2

(1) Particular terms in the General Terms and Conditions hereof shall mean the following:

1) **Insurer** under the voluntary health insurance (hereinafter: the Insurer), as applied in the Terms and Conditions hereof, shall be deemed Dunav Insurance Company a.d.o. that organizes and effects voluntary health insurance in accordance with the law;

2) **Insured** under the voluntary health insurance (hereinafter: the Insured) is an individual having concluded a contract on voluntary health insurance or on whose behalf the voluntary health insurance contract has been concluded with the voluntary health insurance Insurer and who exercises the rights stipulated under the voluntary health insurance contract, as well as a family member of such Insured, for whom the voluntary health insurance has been contracted;

3) **Policyholder** under the voluntary health insurance (hereinafter: the Policyholder) is an entity or individual and/or any other legal person who, on behalf and for the account of the voluntary health insurance Insured and/or on his own behalf and for account of the Insured under the voluntary health insurance concludes the voluntary health insurance contract debiting his own funds or the account of the voluntary health insurance Insured;

4) **Proposal** is an offer to conclude a contract on voluntary health insurance handed over by the Insurer to a person who wishes to conclude a contract on voluntary health insurance;

5) **Policy** of voluntary health insurance (hereinafter: the Policy) is a document on the contract on voluntary health insurance concluded with the Insurer;

6) **Premium** of voluntary health insurance (hereinafter: the Premium) is the amount of money that the voluntary health insurance Insured / Policyholder pays to the Insurer upon conclusion of contract on voluntary health insurance;

7) **Cover note** is a document that temporarily replaces a Policy and includes all relevant elements of the insurance contract;

8) **Family members** are a spouse or common law partner and children of the Insured, provided they are named on the Policy and in consideration of the insurance premium having been paid for them. The children are deemed family members if born in or out of the wedlock, adopted, stepchildren or taken for support until the full age of 18 or up to the full age of 26 if attending a regular school;

9) **Healthcare services** are services provided by the health care service providers under the Law regulating health protection, with the aim to provide health protection and/or implement measures for preserving and improving health of people, prevention, control and timely detection of diseases, injuries and other health impairments, treatments and rehabilitation, including medical services of traditional medicine that are safe, high-quality and efficient;

10) **Health care service providers** are medical institutions and /or private practice or other entities that have been issued a licence by a Ministry in charge of the health affairs to carry out particular health care services pursuant to the law regulating the health protection and regulations enacted for the enforcement of such law.

11) **Network of health care service providers** are all the health care service providers that have, within a period of the insurance contract, signed with the Insurer an effective contract on the provision of health care services, where the Insured may use the services agreed under the insurance Policy and stipulated under the General and Special Terms and Conditions. The Insurer shall classify the healthcare service providers into the appropriate groups of the Network of healthcare service providers according to the standard service level and other relevant criteria;

12) **Medical institution** is an entity practising health care and granted a licence from the Ministry in charge of health affairs to practise health care in accordance with the law regulating health protection and the regulations enacted for the enforcement of such law;

13) **Private practice** is a form of health care services where particular health care activities are being carried out and that has been granted a licence by the Ministry in charge of the health affairs to practise particular healthcare activities pursuant to the law regulating the health protection and the regulations enacted for the enforcement of such law;

14) **Other healthcare service providers** are other entities or individuals practising particular healthcare activities and/or providing for medical and technical aids that have been issues a licence by the competent body for the practice of such affairs in line with the law;

15) **Authorised health professional and health assistant** are persons who, directly as a profession, practice the health care activities in medical institutions or private practice, under the conditions prescribed by law regulating the health protection;

16) **Medical call centre** is a telephone service of the Insurer or the assistance company that operates 24 hours a day and allows the Insured the contact with medically educated persons who provide medical assistance when the insurance is effected as regulated under the Special Terms and Conditions of Voluntary Health Insurance;

17) **Medicine** is a product licensed for launching on the market in the Republic of Serbia as well as the product that has not been licenced for launching on the market 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;

18) **Medical and technical aids** are medical devices intended for functional and aesthetic replacement of the lost body parts i.e. for providing support, prevention of deformities/rectifying existing deformities and facilitating basic vital functions;

19) **Implant** is a medical device that is surgically built in human organism;

20) **Pecuniary compensations** in the voluntary health insurance are the compensations that the Insurer provides to the Insured under the Voluntary health insurance in the following cases: agreed medical expenses; loss of earnings and /or salary or other income due to temporary work incapacity; reimbursement of transportation expenses incurred for medical treatment and other types of pecuniary compensations in connection with exercising rights under the voluntary health insurance, as stipulated under the Special Terms and Conditions of voluntary health insurance;

21) **Sum insured** is the agreed maximum amount of the obligation of the Insurer specified in the insurance Policy;

22) **Insured event** is a future, uncertain event occurring suddenly, independently and beyond the will of the Policyholder / Insured, the occurrence of which shall trigger, in accordance with the law and the insurance contract, the Insurer's liability to indemnify the Insured or perform other actions;

23) **Insurance cover** is a cover of reasonable medical expenses according to the insurance contract and Special Terms and Conditions for voluntary health insurance;

24) **Waiting period** is the agreed period at the beginning of the contracted insurance period during which the Policyholder is obliged to pay the insurance premium and the Insurer is not obliged to pay the insurance indemnity, regardless of the occurrence of the insured event stipulated under the Special Terms and Conditions of voluntary health insurance of the Insurer;

25) **Refund** is the right of the Insured to recover from the Insurer the medical expenses or part thereof incurred by exercising the rights under the

contract on voluntary health insurance, as stipulated under the Special Terms and Conditions of voluntary health insurance and the Policy;
26) **Participation** represents the share of the Insured in the payment of the agreed fee for healthcare services when stipulated under the Special Terms and Conditions of voluntary health insurance;
27) **Document on voluntary health insurance** (hereinafter: Document) is a document that the Insurer issued to voluntary health insurance Insured based on which the voluntary health insurance Insured proves his capacity of the person insured under voluntary health insurance and exercises the rights under voluntary health insurance;
28) **Special Terms and Conditions of voluntary health insurance** (hereinafter: Special Terms and Conditions) are the Insurer's Terms and Conditions regulating the rights and obligations of the contracting parties for a particular type or combination of types of voluntary health insurance that are an integral part of the insurance contract and shall be handed over to the Policyholder.

Types of Voluntary Health Insurance
Article 3

(1) In accordance with the Law on Health Insurance, the Insurer shall effect the following lines of Voluntary health insurance:
1) Supplementary Health Insurance – insurance covering the costs of health protection incurred when the Insured supplements his rights under Mandatory Health Insurance in contents, scope and standard;
2) Additional Health Insurance – insurance covering the participation in the costs of health care and/or the costs of health care services, medicines, medical devices and pecuniary compensations that are not covered under the mandatory health insurance;
3) Private Health Insurance – insurance of persons that are not covered by mandatory health insurance, used to covering the costs of the type, contents, scope and standard that are being contracted with the Insurer;
4) Combination of supplementary, additional and private voluntary health insurance;
5) Voluntary health insurance contracted in case of using health protection of the Insured under voluntary health insurance while staying in a foreign country.

General and Special Terms and Conditions of Types of Voluntary Health Insurance that Insurer Arranges and Transacts
Article 4

(1) General Terms and Special Terms and Conditions shall form an integral part of the contract on voluntary health insurance that the voluntary health insurance Policyholder concludes with the Dunav Insurance Company a.d.o.
(2) The General and the Special Terms and Conditions shall be adopted by the competent body of the Insurer in accordance with the legal regulations.
(3) The Special Terms and Conditions of voluntary health insurance shall comprise:
1) Terms and Conditions for organizing, contracting and implementing a particular type of voluntary health insurance;
2) Rights and obligations of the Insurer, voluntary health insurance Insured / Policyholder under a particular type of voluntary health insurance;
3) Other terms and conditions relevant for organization and implementation of a particular type of voluntary health insurance, in accordance with the Law on Health Insurance and Law governing insurance industry.
(4) The Insurer shall publish the General and Special Terms and Conditions on their official website and make them available at all Insurer's points of sale.

Eligibility
Article 5

(1) Any person shall be eligible for supplementary and additional voluntary health insurance if such person has a status of the Insured under mandatory health insurance scheme of the Republic of Serbia and expresses a clear intent to conclude a contract on supplementary / additional voluntary health insurance with the Insurer according to the General and the Special Terms and Conditions.
(2) With the termination of the status of Insured under mandatory health insurance scheme, the status of Insured under voluntary supplementary and additional health insurance shall terminate, regardless of the period to which the contract on voluntary health insurance was signed.
(3) Any person shall be eligible for private voluntary health insurance if such person is not covered under mandatory health insurance but does express a clear intent to conclude a contract on insurance with the Insurer according to the General and Special Terms and Conditions hereof.
(4) The Insured's family members defined in the Special Terms and Conditions of the Insurer may acquire the status of the Insured provided a voluntary health insurance has been agreed for them and in consideration of payment of the agreed premium.
(5) Any person may be eligible for insurance if, at the moment of applying for insurance contract conclusion, such person does not owe any outstanding premiums under previous contracts on voluntary health insurance to the Insurer.

Conditions for Concluding Contracts on Voluntary Health Insurance with Insured / Policyholder
Article 6

(1) The Insurer shall grant all the voluntary health insurance Insured the same scope, content and standard for exercising rights and obligations under the particular types of voluntary health insurance that the Insurer is arranging and transacting.
(2) Depending on the degree of risk the Insured is exposed to, the Insurer shall have the right to set the amended insurance terms and conditions and/or increase premiums or change the amount or scope of cover.
(3) Contract on voluntary health insurance (hereinafter: insurance contract) shall be concluded by and between the voluntary health insurance Insurer and Policyholder/Insured. The insurance contract may also be concluded for the family members of the voluntary health insurance Insured, under group voluntary health insurance.
(4) If voluntary health insurance Policyholder / Insured are not the same person, written consent of the Insured shall be required for contracting the voluntary health insurance, in the case where the voluntary health insurance Insured is paying the premium.

Application for Conclusion of Contract on Voluntary Health Insurance
Article 7

(1) Contract on voluntary health insurance is concluded based on the preliminary application for the conclusion of contract on voluntary health insurance (hereinafter: Proposal) that the Insurer presents to the person who wishes to conclude a contract on voluntary health insurance.
(2) The Application includes material information about the contracting parties and/or the Insured under voluntary health insurance, insurance inception date, waiting period for insurance as well as date of insurance ending, amount and due dates for premium payment, maximum agreed sums per covered risks and other material elements for insurance contracting.
(3) The material information on contracting parties and/or the Insured under voluntary health insurance are:
1) for individuals:
- name and surname as well as date of birth of the voluntary health insurance Insured
- personal ID number, that is, the registration number for foreign nationals,
- address of stay or residence in the Republic of Serbia (street and number, place and municipality),
- contact (telephone number or email address);

2) for entities:
- name or business name,
- taxpayer's number and registration number,
- seat address (street and number, place and municipality),
- contact (telephone number or email address).

(4) In the case of concluding group insurance contract, the Policyholder may submit a single application that includes data on the persons to be included into group insurance, such as:
1) name and surname, date of birth of the voluntary health insurance Insured;
2) personal identification number or the registration number for foreign nationals;
3) address of stay or residence in the Republic of Serbia (street and number, place and municipality);
4) contact (telephone number or email address).

(5) Application and/or a single application shall include, as material, data on previous health condition of the voluntary health insurance Insured, that the Insurer requires for the assessment of insurance risk.
(6) Policyholder / Insured shall be obliged, when concluding the insurance contract, to notify the Insurer of all the circumstances material for risk assessment that they are aware or must have been aware of.
(7) The Insurer shall not ask for genetic data or genetic test results for hereditary diseases when concluding an insurance contract for a person

who expresses a clear intention to conclude a voluntary health insurance contract with the Insurer, as well as that of his relatives, regardless of lineage and degree of relationship.
(8) When contracting, the Insured shall be obliged, upon request of the Insurer, to complete the Health Questionnaire which is an integral part of the application, undergo a medical examination with an authorized health professional / associate and submit other required documentation needed for assessing the risk.
(9) The Questionnaire shall comprise general identification data on the Insured and the questions on the health condition of the Insured relevant to the Insurer for risk assessment, defining desired coverage and stating the insurance premium.
(10) Data from the Questionnaire may not be the cause for denial of coverage. Based on the data from Questionnaire, the Insurer shall be entitled to propose insurance under amended conditions for persons with aggravated risk, charging the additional insurance premium or introducing limitations and/or exclusions of liability under particular coverages.
(11) Written proposal for conclusion of insurance contract shall be binding upon the Insurer during the period of 8 days following the date when the Policyholder received the proposal, unless the Insurer has defined a shorter period.
(12) If in the period from the submission of the application until the conclusion of the insurance contract the Insured health risk should aggravate, the Insured / Policyholder shall notify the Insurer as soon as he becomes aware of such aggravation. The aggravated health risk of the Insured shall be deemed any illness or disease, change in occupation, injury of the Insured, practicing sports or traveling to crisis areas, tropical regions or expeditions, as well as other changes that increase the Insured's health risk.
(13) If, in the case of a general check-up or other medical examination in the course of 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 that the Insured did not declare in the application, the Insurer may propose the coverage under the amended terms and conditions.
(14) If the Policyholder /Insured does not agree to the amended conditions within 8 days following the receipt of the notice with the insurance proposal at the amended terms and conditions of the Insurer, the contract shall be deemed terminated upon expiry of such period. In the event of contract termination, the Insurer shall be entitled to the entire amount of the due premium.
(15) All documents that are delivered to the Insurer by the Policyholder 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. By signing the Application, the Insured / the Policyholder shall confirm that they accept the General and Special Terms and Conditions.

Concluding Contract on Voluntary Health Insurance and /or Group Insurance for Family Members of Insured
Article 8

(1) Group insurance is voluntary health insurance concluded by the Policyholder with the Insurer of his election pursuant to the law, on his own behalf and for account of the Insured. If the premium is paid by the Insured, the written consent of the Insured shall be required in order to arrange voluntary health insurance.
(2) Under the group voluntary health insurance, the Insured may also be any family member of the Insured, if the insurance has been agreed for them, due premium paid and provided such a member is sharing the same household with the Insured.

Policy, Cover Note and Document
Article 9

(1) The Insurer shall issue the Policy as evidence of concluded insurance contract.
(2) The Insurer shall compose the Policy in two copies, one of which shall be retained by the voluntary health insurance Policyholder / Insured and the other one by the Insurer. By way of exception, the Insurer may issue a cover note.
(3) With the group insurance, the Insurer shall issue one Policy to the Policyholder for all insured persons.
(4) The Policy / Cover Note shall include:
1) name and surname of the voluntary health insurance Insured / Policyholder, that is the title of the Policyholder;
2) date of birth of the voluntary health insurance Insured;
3) the place of residence / stay and address of the Insured or the Policyholder, or the seat of the Policyholder;
4) Personal identification number / registration number for foreign nationals, that is, the taxpayer's number and the personal identification number of the Policyholder;
5) the name and address of the Insurer;
6) insurance coverage;
7) the sum and risk insured;
8) the amount of insurance premium, the method and conditions of premium payment;
9) reference to the tariff according to which premium is calculated;
10) number of Policy or Cover Note;
11) number of application for the conclusion of the voluntary health insurance contract;
12) date of insurance inception, waiting period of insurance and term of insurance and /or Policy or Cover Note validity;
13) signature of authorised person for the Insurer;
14) signature of voluntary health insurance Policyholder;
15) place and date of issuance of the insurance Policy / Cover Note;
16) other information according to the law.

(5) The last page of the Policy and / or Cover Note shall include the printed General and Special Terms and Conditions of voluntary health insurance type that has been arranged and transacted by the Insurer, which form an integral part of the concluded insurance contract; otherwise, the Form with specially printed General and Special Terms and Conditions shall be handed over to the Insured / Policyholder, who shall confirm the receipt and acceptance thereof by affixing their signature.
(6) Where the voluntary health insurance contract is effected in the case of use of health care services by the voluntary health insurance Insured during the stay of the Insured in a foreign country, the Policy and /or Cover Note shall also contain the passport number of such Insured, the name of issuing authority and dates of issue and validity of the passport.
(7) Under the insurance Policy, the Insurer shall be obliged to issue to each Insured a Document on the basis of which the Insured shall exercise his rights under the voluntary health insurance policy, at the Policy issue date but not later than 60 days from the date of Policy issue.
(8) The Document shall include the following information:
1) business name of the Insurer;
2) name and surname as well as date of birth of the Insured;
3) personal identification number of the Insured, i.e. the registration number for foreign nationals;
4) scope of the cover;
5) Policy number;
6) document validity period
(9) The rights under voluntary health insurance shall be exercised on the basis of the Document, and exceptionally on the basis of the Policy or Cover Note until the moment of obtaining the Document. In the case of loss of the Document, the insurance rights shall be exercised on the basis of the Policy until the moment the duplicate Document is issued.
(10) In the case of loss of proof of concluded insurance contract, the Insured shall be obliged to notify the loss to the Insurer.
(11) In the case of insurance contracts concluded for up to 90 days, the Insured shall exercise his rights under voluntary health insurance on the basis of a Policy. In the case where the rights under voluntary health insurance are exercised directly with the Insurer, they shall be exercised on the basis of the insurance Policy or Cover Note.
(12) An integral part of a group insurance contract shall be a list of the Insured or an extract from the Policyholder's human resource records of persons covered under voluntary health insurance. The Insurer shall issue a Document to each Policyholder from the list or from the records of the Policyholder not later than 60 days from the Policy issue date.
(13) The Insured shall be liable to submit for the inspection of the health care service provider with whom he undergoes the health care services under the voluntary health insurance contract, a document, Policy or cover note on the basis of which the Insured exercises his rights under voluntary health insurance. Attached to the proof of insurance, the Insured must also submit an identification document that includes a photograph.

Insurance Inception and Duration
Article 10

(1) Voluntary health insurance shall be contracted for a period of not less than 12 (twelve) months from the date of insurance inception.
(2) Voluntary health insurance can be shorter, namely:
1) During the stay of the Insured in a foreign country, that is, to cover the costs of health care provided abroad;
2) In the case where the status of the Insured in the mandatory health insurance system lasts for a shorter period;

3) During the temporary stay in the Republic of Serbia of the Insured who is a foreign national or a person without a citizenship;
4) For persons who, during the contractual insurance period, have become eligible for insurance under group contracts;
5) If the issuance of an insurance Policy is preceded by the conclusion of the cover note.

Article 11

(1) The Insurer's obligations shall attach as of the 24:00 hours of the date stated in the Policy as the voluntary health insurance inception date, provided the payment of the insurance premium, that is, the due instalment of the insurance premium (where the premium payment has been contracted in instalments).
(2) If the payment has been effected after the date stated in the insurance Policy as the insurance inception date, the insurance shall commence as at 24:00 hours of the date when the agreed premium has been paid, unless otherwise agreed.
(3) The insurance contract shall terminate upon expiry of the 24:00 hours of the last day of the period for which the insurance has been agreed, stated in the insurance Policy.

Waiting Period
Article 12

(1) Waiting period can be stipulated in accordance with the insurance contract.
(2) Waiting period is a period from coming into effect of the insurance contract to the moment of full risk assumption by the Insurer.
(3) Waiting period shall be calculated starting from the insurance inception defined in the Policy, provided the first agreed due premium has been paid before such date.
(4) If due premium is not paid prior to the insurance inception, the waiting period shall run as from the 24:00 hour of the date when the first agreed premium has been paid.
(5) The waiting period shall not apply to the renewal of insurance contract, unless otherwise specified in the contract.
(6) The waiting period shall not apply to the renewal of insurance contract only for the Insured 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 period of insurance under the new Policy.
(7) For particular insurance coverages, the Insurer may also stipulate the waiting period in accordance with the Special Terms and Conditions of the Insurer.

Rights and Obligations of Policyholder and Insured
Article 13

(1) The Policyholder / Insured shall exercise the rights under concluded insurance contract, the General Terms and Conditions and the Special Terms and Conditions of the Insurer.
(2) The rights under the insurance contract may not be assigned to third parties nor inherited. Balances due for payment and remaining unpaid because of the death of the Insured may be inherited in accordance with the provisions of the Law.

Article 14

(1) The Policyholder / Insured shall be obliged to duly pay the Insurer the insurance premium when due, within the periods defined under the insurance contract or Policy.
(2) The Policyholder / Insured shall be obliged to return the Insurer the Document on insurance for persons that have lost the status of the Insured prior to expiry of the insurance contract.

Article 15

(1) The Policyholder / Insured shall be obliged to disclose to the Insurer, when concluding the insurance contract, all the circumstances material for the risk assessment that he is aware or must have been aware of.
(2) Policyholder / Insured shall be obliged to respond completely and accurately to the questions listed in the Application and Questionnaire Forms regarding the health condition of the Insured. The Insured shall undertake, when necessary, to undergo check-up with a physician determined by the Insurer, in order to define the circumstances relevant for the grounds and amount of obligation under the insurance contract.
(3) When exercising the rights under the voluntary health insurance, the Insured shall be obliged to previously call the Medical Call Centre of the Insurer and provide for the necessary identification data (Insurance Document number or name and surname, date of birth, name of the Policyholder and the Policy amount as well as the type of disease or accident) for exercising the rights under concluded insurance contract and to accept medical treatment with the health care service provider from the Insurer's Network of health care service providers, unless the treatment outside the Network has been agreed and allow the insight into the Policy or the Document on insurance to the authorised person of the health care provider.
(4) Exceptionally, if so agreed, when exercising the insurance rights the Policyholder / Insured will pay out of their own pocket for the costs of health care services provided by the health care service provider with whom the Insurer does not have a contract on business cooperation.
(5) If the Insured has paid for the expenses of the provided health care service out of his own pocket, the Insured shall be obliged, within one month from the day of the completion of treatment, to submit a claim for reimbursement of medical expenses to the Insurer, and provide all necessary information and supporting documentation regarding the insured occurrence, for the purpose of establishing the grounds, scope and amount of Insurer's obligation. Otherwise, the Insurer shall not be liable to bear the increased costs. Upon invitation of the health care service provider or Insurer, the Policyholder or Insured shall be obliged to pay the amount in excess of the agreed sum insured.
(6) The Insured shall be obliged to authorize physicians and health care service providers to deliver, upon request of the Insurer and with regard to the insured occurrence, all relevant information regarding the treatment of the Insured, as well as all the required information regarding the previous medical condition of the Insured.
(7) If, due to his health condition, the Insured is not capable to act immediately in the manner stipulated in the Article hereof, the Insured shall do so as soon as his health condition allows. This obligation may be fulfilled by a third party (relative, fellow traveller, health care service provider who received the Insured etc.) on behalf of the Insured.

Insurer's Obligations
Article 16

(1) The Insurer shall allow the voluntary health insurance Insured to exercise the rights under the insurance contract as well as the rights defined under the General and Special Terms and Conditions of the Insurer for the type or combination of types of insurance.
(2) The Insurer shall allow the provision of health care services to Insured under the voluntary health insurance in the medical institutions, private practice or other health care providers with whom the Insured has concluded contracts for the provision of health care services, regulating the method of provision of health care services. The list of such medical institutions is available at the Insurer's website.
(3) Pursuant to the insurance contract / Policy and Special Terms and Conditions, the Insurer shall reimburse the Insured or provider of the health care services with whom the Insurer has signed the contract on the provision of health care services for the expenses or part of expenses incurred in exercising the rights under insurance contracts.
(4) The agreed sum insured, individual sublimit and agreed scope of services defined in the Policy shall represent the upper limit of Insurer's obligation per any one occurrence for the entire agreed insurance period.
(5) If the costs arising from the occurrence of the insured event are less than the sum insured defined in the insurance contract, the Insured shall not be entitled to receive the payment of balance.
(6) Pursuant to the insurance contract and/or Policy and Special Terms and Conditions, the Insurer shall undertake to reimburse the Insured for the costs or part of costs incurred in exercising the rights under voluntary health insurance or for the amount of agreed pecuniary compensation within 14 (fourteen) days following the date when the Insurer received complete documentation on the basis of which he can determine the indisputable existence and scope of liability.
(7) The Insurer shall be entitled to ask for any additional explanation or documents from the Insured, Policyholder or a third party entity or individual in order to establish material circumstances about the notified insured event.
(8) 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.
(9) Pursuant to the law, the Insurer shall undertake to pay due pecuniary compensations that remain outstanding because of the Insured's death to the Insured's heirs.

Article 17

(1) The Insurer shall not be obliged to pay indemnity i.e. reimburse for the medical expenses in the following cases:

1. If the Policyholder / Insured has disclosed untrue and inaccurate information, withheld material circumstances that could have affected the conclusion of the insurance contract or in the event of intended fraud or abuse;
2. If the Policyholder / Insured or any third party acting on their behalf failed to settle due insurance premium prior to the agreed term;
3. In the event of misuse of a Policy or Document;
4. If the scope of agreed medical services and the amount of costs and sum insured have been exceeded;
5. If the claim is based on false data and false documentation.

(2) The Special Terms and Conditions of the Insurer for individual type of voluntary health insurance or a combination of supplementary, additional and/or private voluntary health insurance stipulate the exclusions that are particular and relate only to such type of insurance.

Article 18

(1) The obligation of the Insurer shall be reduced pro rata paid insurance premium and the insurance premium that should have been paid for the actual risk, if the right to indemnity is the result of an incorrectly declared health condition at the time of conclusion of the insurance contract.
(2) If the Insured, in order to obtain unlawful property gain for himself or a third party individual or entity by false presentation or concealment of facts, misleads the Insurer or keeps him mislead, causing the Insurer to act or fail to act at the detriment of his or a third party property, the Insurer can file a criminal complaint against such Insured.

Insurance Premium
Article 19

(1) The insurance premium is a monetary amount payable by the Policyholder / Insured to the Insurer according to the concluded contract on voluntary health insurance.
(2) The Insurer shall define the insurance premium in line with the regulations and valid tariffs of voluntary health insurance. The premium amount and method of payment shall be contractually agreed.
(3) Considering the risk to which the Insured is exposed, that is, considering the years of life of the Insured at the time of delivering the Application, bonus, malus, health condition of the Insured, that is the illness and mortality tables, the premium for a particular type of voluntary health insurance Policy shall equal for all the Insured included under such voluntary health insurance Policy that are exposed to the same degree of risk.
(4) The Policyholder shall pay the insurance provider an insurance premium duly, within the deadlines set under the contract on voluntary health insurance or insurance Policy. The Insurer shall accept the premium paid by any third party who has a legal interest in fulfilling this obligation.
(5) For insurance contracts concluded for a period up to 12 (twelve) months, the Insurer shall not be allowed to increase the agreed premium amount.
(6) The insurance premium may change in the event that the Policyholder, when concluding the voluntary health insurance, withheld circumstances material for the risk assessment.
(7) With the insurance contracts, the premium may be changed upon expiry of the period of 12 (twelve) months from the date of conclusion of the insurance contract and/or per every 12 (twelve) months until the expiration of the term to which the insurance contract was concluded. In case of increasing the insurance premium, the Insurer shall be obliged to inform Insured in writing of the premium increase not later than 30 (thirty) days prior to the expiry of the current insurance year and include the explication.
(8) The Insurer shall be entitled to an annual premium amount, regardless of the contractual method of premium payment (semi-annual, quarterly or monthly). The Insurer shall be entitled to charge the Policyholder, that is the Insured, the statutory penalty interest for each day of overtime beyond the period within which the Policyholder /Insured was obliged to pay the premium due. The payment of the overdue premium instalment shall always refer to the first unpaid premium instalment.
(9) If a premium is paid through a post-office, it shall be deemed paid at 24:00 hours of the date when payment was effected at the post office, and if the premium is paid through a bank, it shall be deemed paid at 24:00 hours of the date when the order was delivered to the bank.

Termination of Insurance Contract
Article 20

(1) The insurance shall terminate by expiry of the agreed period.
(2) The insurance shall terminate before the expiry of the agreed period in the following cases:

1. death of the Insured – as of the date of death;
2. termination of the insurance contract;
3. cancellation of the insurance contract.

Termination of Insurance Contract
Article 21

(1) If the Policyholder and/or Insured fails to pay the due agreed insurance premium, that is the premium instalment until the agreed term, nor any third party does so on behalf of the Insured/Policyholder, the Insurer's obligation to cover the expenses and /or part of expenses for the provision of healthcare services under voluntary health insurance contract or a Policy shall cease upon expiry of 30 (thirty) days following the date when the Policyholder was handed over a written notice of the due outstanding insurance premiums.
(2) Upon expiry of the term referred to under the paragraph 1 of the Article hereof, the Insurer may terminate the insurance contract unilaterally with no subsequent notice period and institute the procedure for the collection of due premiums inclusive of the interest charged, before the competent court.
(3) The Insurer may terminate the voluntary health insurance contract signed for the benefit of supplementary or additional voluntary health insurance Insured prior the expiration of the period to which such contract was concluded, if, during the contract period, such Insured was terminated the status of Insured under the compulsory health insurance scheme.
(4) If the Policyholder unintentionally made a false application or failed to give due notice the Insurer may, if so elects, within one month after he has learned of such inaccuracy of incompleteness of the application, state that he shall terminate the contract or propose a premium increase in proportion to the increased risk.
(5) In such case, the contract shall terminate upon the expiration of fourteen days after the Insurer has communicated his termination statement to the Policyholder and in the case of the insurer's proposal to increase the premium, the termination shall occur by law if the Policyholder fails to accept the proposal within fourteen days of receiving such proposal.
(6) In the event of termination, if there was no damage during the period of insurance, the Insurer shall be obliged to repay the part of the premium referring to the period of time left until the end of the insurance period.
(7) If the insured event occurred prior to the detection of inaccuracy or incompleteness of the application, or after the detection but before the termination of the contract or before reaching an agreement on the premium increase, the indemnity shall be reduced pro rata balance between the paid premium and the premium that should have been paid with regard to the actual risk.
(8) The Special Terms and Conditions of the Insurer for the type of voluntary health insurance shall regulate the notice period and the method of termination of the insurance contract.

Cancellation of Insurance Contract
Article 22

(1) If the Insured deliberately misrepresented or withheld a circumstance of such a nature that the Insurer would not have concluded the insurance contract under the same circumstances if he had known for the real situation, the Insurer may require that the insurance contract be cancelled.

Insurance Renewal
Article 23

(1) When the Insured wishes to renew 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 indemnity under the Terms and Conditions from the insurance contract valid on the date of insured occurrence.

Filing Complaints
Article 24

(1) A user of an insurance service (the Insured, Policyholder) may file a complaint against the work of the Insurer, in person or through representative or an attorney. The complaint is filed in writing, by filling in a default Form downloadable from the web page or in the business premises, or in a free form, in one of the following ways:
- by submission into business premises of the Insurer where the service is offered,
- by filling in a Form at the Internet page www.dunav.com,
- by an e-mail at: prigovor@dunav.com,
- by mail, at the address of Makedonska 4, 11000 Beograd.

The following documents need to be enclosed with the complaint:
- identity data and the electronic address of the Claimant,
- type of service to which the Complaint refers (name of the organizational unit that provided the service, the type of service, number of claims file and/or Policy number),
- contents of the Complaint (reasons for the Complaint and the request of the Complainant),
- the evidence supporting the statements from the Complaint,
- date of filing the Complaint,
- signature of Complainant and/or his representative or attorney, unless the Complaint is electronically submitted,
- special power of attorney in case the Complaint is submitted by an attorney, whereby the user of the insurance service shall authorize the attorney to submit a Complaint on behalf and for the account of the user, with regard to work and services provided by Dunav Insurance Company a.d.o. and take actions in any litigation upon such Complaint and whereby the user shall grant permission to make available to such attorney any data relating to the user as are deemed personal data under the law regulating the protection of personal data and/or secret data under any other laws and/or regulations.

(2) The Insurer shall undertake to submit a response to the Complaint in writing, enclosing the instructions on legal remedy, not later than 15 (fifteen days) from the day of receipt of the Complaint. Exceptionally, the specified deadline can be extended by a maximum of 15 (fifteen) days, about which the Insurer shall inform the Complainant in writing.

Processing Data on Insured
Article 25

(1) The Policyholder and Insured shall authorize the Insurer to collect, verify, process, store and use the personal data of the Insured that are required for the conclusion of the insurance contract as well as for establishing the right to indemnity. The processing of personal data, their archiving and protection measures shall be effected in accordance with the law governing the protection of personal data.
(2) The insurer shall keep the information referred to in the paragraph 1 of the Article hereof as a trade secret, in accordance with the law.

Disclosure of Information
Article 26

(1) The Insurer shall undertake to provide the Insured with all information, as well as the necessary documentation or extracts from the documentation kept by the Insurer in a timely manner and without paying any fee, that refer to effecting the voluntary health insurance and are material for exercising the rights under voluntary health insurance, as well as the information on the medical institutions, private practice or other health care services providers where they can exercise their rights under voluntary health insurance, excluding the information that represent a trade secret.

Applicable Law and Jurisdiction
Article 27

(1) Implementation, effect and construing of insurance contract concluded under the General Terms and Conditions hereof shall be subject to the law and jurisdiction of the Republic of Serbia.

Article 28

(1) Aging of accounts receivable under the insurance contract shall be regulated under the relevant provisions of the Law on Contracts and Torts.

Subrogation
Article 29

(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 of him with relation to the claim for indemnity. The costs of obtaining this evidence shall be borne by the Insurer.
(3) If the Policyholder or Insured receives compensation from a third party liable for the damage, the Insurer shall be entitled to deduct this amount from the indemnity to be paid to the Insured under the insurance Policy.

Application of General Terms and Conditions
Article 30

(1) General Terms and Conditions of Voluntary health insurance may be amended following the same procedure and method as for their adoption.
(2) The Insurer shall be obliged to inform the Policyholder with whom he has concluded an insurance contract with the long-term period on any amendments to the General or Special Terms and Conditions of voluntary health insurance, and he shall do so in writing, with an explication not later than 30 days prior to the expiry of the current insurance year, unless such amendments are more favourable for the Policyholder.
(3) In the case of amendment to the General Terms and Conditions during the insurance period with long-term period of insurance, the application of the new Terms and Conditions may be agreed starting from the following long-term insurance period.

Transitory and Final Provisions
Article 31

(1) The matters not regulated under the General Terms and Conditions hereof shall be governed by the provisions of the Law on Contracts and Torts, Law on Health Insurance, Law on Insurance and clauses of other legal regulations of the Republic of Serbia that govern this area of insurance industry.

Article 32

(1) The General Terms and Conditions hereof shall be posted on the internet page of the Insurer.
(2) By coming into effect of the General Terms and Conditions hereof, the validity of the General Terms and Conditions of Voluntary health insurance (Company Bulletin, No. 53/18) shall terminate.
(3) The General Terms and Conditions hereof shall come into force and shall apply as of the date of their publishing in the Company Bulletin.

THIS VERSION OF THE TERMS AND CONDITIONS SHALL APPLY AS OF 23 DECEMBER 2022