TRANSLATION OF INSURANCE TERMS AND CONDITIONS
FOREIGNERS' COMPREHENSIVE MEDICAL INSURANCE PLUS

KZPC PLUS 1/17
effective as of 1. January 2017

Article 1
Introductory Provisions
1. The rights and responsibilities of parties to this Foreigners' Comprehensive Medical Insurance PLUS (hereinafter "Insurance") are governed by the laws of the Czech Republic, particularly the Civil Code, Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up the insurance contract for these purposes.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer.

Article 2
Definition of Terms
The following definitions of terms shall apply for the purposes of this:
1. The Qualifying Period is the period in which the Insurer has no obligation to provide Insurance Benefits for events which would otherwise be Insured Events. The Qualifying Period is counted as of the day agreed as the commencement of the Insurance Period.
2. The Duration of the Insurance is the actual period of time of the agreed Insurance Period for which the Insurance was in effect.
3. One Insured Event is an Insured Event arising from the occurrence of the Insured Event caused by an Insured Peril.
4. A Single Insurance Period is a period determined for the entire period for which the Insurance has been agreed.
5. Comprehensive Healthcare is understood to mean healthcare provided to the Insured Person in the Insurer's contractual healthcare facility which is the direct payer of the treatment costs in order to preserve higher state of health at a time prior to the conclusion of the insurance policy.
6. An Injury is understood to mean the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or interest is transferred, the Insurers' obligations in respect of the occurrence of an Insured Event.
7. Loss Event is understood to mean the occurrence of an Insured Event.
8. The Insurer is entitled to reduce the Insurance Benefit by an amount equal to the ratio of the extent of the damage caused.
9. An Interim payment is an advance in concluding an insurance policy with the Insurer.

Article 3
Purpose and Subject of the Insurance
1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the Insured Person.
4. The Insurance is concluded as Loss Insurance.

Article 4
Insured Event
With the exception of the agreed exclusions, an Insured Event is a change in the medical condition of the Insured Person or other acts related to the medical condition of the Insured Person caused by an Illness or Injury occurring within the Duration of the Insurance and after the expiry of the Qualifying Period and during the Insured Person's stay at the place of Insurance.

Article 5
Extent and Place of Insurance
1. The extent of the agreed Insurance is determined by the insurance terms and conditions and elective parameters stipulated in the insurance policy. Two or more private insurance policies relate to the same insurance risk covered by these two or more private insurance policies.
2. The extent of the Insurance is the Sum Insured.
3. The Insurer is entitled to reduce the Insurance Benefit proportionally to the extent of the damage caused.
4. The Insurer is entitled to reduce the Insurance Benefit by an amount equal to the ratio of the extent of the damage caused.
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19. The Insurer is entitled to reduce the Insurance Benefit by an amount equal to the ratio of the extent of the damage caused.
10. The Insurer may also refuse to pay the Insurance Benefit if, when exercising its rights to benefit under the Insurance, the Beneficiary knowingly gave false or grossly distorted information with the purpose to obtain an Insurance Benefit or withheld material information pertaining to this Insured Event.

11. A loss comprises of the reasonable costs demonstrably incurred on healthcare provided to the Insured Person in the place of the Insurance in accordance with the valid healthcare acts and legal regulations, at healthcare facilities with which the Insurer has concluded an agreement with respect to this Insurance.

In the event of a sudden deterioration in the state of health of the Insured Person, where a delay may result in serious damage to health or a threat to life, the Insurer shall also defray costs to a healthcare facility on the territory of the Czech Republic which has not concluded an agreement with the Insurer with regard to this Insurance. Necessary and reasonable costs demonstrably incurred for healthcare services shall be defrayed, but only until such time as it was possible to arrange healthcare by the Insurer’s contractual healthcare facility.

The Insurer shall provide Insurance Benefits up to the limits set out in paragraph 10 of this article to the following extent:

a) healthcare services to an extent similar to those of public medical insurance to the extent of comprehensive healthcare, though with the agreed exclusions from the Insurance and with the agreed Insurance Benefits, b) vaccinations (vaccine and its application) not covered as preventive check-up to determine the current state of health,

c) the awareness of which at the time of the conclusion of the Insurance or during the Qualifying Period, d) vaccinations (vaccine and its application) in a healthcare facility in the Czech Republic, e) vaccinations (vaccine and its application) not covered as preventive check-up to determine the current state of health, f) vaccinations (vaccine and its application) in a healthcare facility in another state in which the Insured Person has been permitted residence, g) vaccinations (vaccine and its application) not covered as preventive check-up to determine the current state of health, h) check-ups and examinations to detect a specific disease (i.e. blood tests, prostate screening, malignant melanoma screening), i) dental hygiene.

Superior standard may also be utilized at any time within the duration of the insurance in individual amounts with a minimum of CZK 100.

13. The costs detailed in paragraph 11 of this article shall be paid by the Insurer directly or via the assistance service provider to the healthcare facility or another party that has demonstrably incurred these costs.

14. Direct defrayment of a loss:

a) if the Insured Person or another party directly defrayed costs of healthcare, which constitute an Insured Event and were provided in a healthcare facility in the Czech Republic, the Insurer shall subsequently, in respect of these healthcare services, settle the reasonable, demonstrably incurred costs to the Insured Person, within the scope of these costs, upon receipt of the originals of the required documents. Originals of these documents remain with the Insurer and are not returned.

b) if an original document has been submitted to the Insurer other than the Insurer, a copy will suffice if the records and confirmations made by this party.

c) the awareness of which at the time of the occurrence of the Insured Event.

d) if, at the time of the occurrence of the Insured Event, the Continuous Hospitalisation of the Insured Person exceeds the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:

i) if the state of health of the Insured Person does not allow for his repatriation, the Insurer shall be entitled to remuneration corresponding to the benefit limits for costs under (a) to (f) of paragraph 1 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

ii) the partial limit detailed under letter (a) of this paragraph is the benefit limit for costs under letter (f) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

iii) the partial limit detailed under letter (a) of this paragraph is the benefit limit for costs under letter (f) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

15. The Insurer shall provide an Insurance Benefit for a doctor prescribed out-patient medicines or a voucher for healthcare aids, if the amount of the claim for each prescription or voucher exceeds a limit of CZK 100. The Insurance Benefit is understood to be the amount prescribed by a doctor or doctor-prescribed medicines, healthcare aids and individually produced medicines, designated as MAX and valid at the time of the occurrence of the Insured Event.

16. The maximum insurance benefit for services in the Continuous Hospitalisation of the Insured Person is determined by the benefit limits stipulated in the insurance policy:

a) the benefit limit for costs under letters (a) to (d) of paragraph 1 of this article (Healthcare services, including repatriation and transportation) limits the Insurance Benefit for every single Insured Event.

b) the partial limit detailed under letter (a) of this paragraph is the benefit limit for costs under letter (f) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

17. The Insurer may be entitled to remuneration corresponding to the benefit limits for costs under letter (a) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

18. If an Insured Event occurred and the continuous hospitalisation of the Insured Person extends the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:

a) if the state of health of the Insured Person does not allow for his repatriation, the Insurer shall be entitled to remuneration corresponding to the benefit limits for costs under (a) to (f) of paragraph 1 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

b) the partial limit detailed under letter (a) of this paragraph is the benefit limit for costs under letter (f) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

19. The partial limit detailed under letter (a) of this paragraph is the benefit limit for costs under letter (f) of paragraph 11 of this article (Postnatal care of a newborn baby), which further limits the Insurance Benefit for all Insured Events occurring within the Duration of the Insurance.

20. If the Insurer consents to the Insurance it is understood that the Policyholder’s insurable interest was demonstrated.

The insurance policy shall be invalid if the Insured Person did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.

The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.

The insurable interest does not terminate upon the absence of the subject of the Insurance from the place of Insurance, the taking up of similar private insurance or for reason of plain dishonesty.

The termination of the insurable interest must always be proven to the Insurer.

1: In addition to the above, the policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

2: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

3: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

4: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

5: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

6: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.

7: The policyholder must provide the Insurer with evidence that the Insured Event falls within the scope of the policy, that the Insured Event does not contravene the terms of the policy, and that the Insurer has not provided any written notice to the contrary.
Article 10

Conclusion of the Insurance Policy

1. The insurance policy is concluded on acceptance of the Insurer's Insurance offer. The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated herein. If the Policyholder accepts the offer by the timely payment of the premium, it shall be deemed that the written form of the insurance policy has been duly observed.

2. The insurance policy is concluded for a definite time period.

3. An integral part of the insurance policy, apart from the insurance policy text, is this Annex and any other agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, content and expiration of the Insurance (e.g. applications, questionnaires, reports, medical examinations and checks, notices, records of the course of concluding the Insurance, the Insurer's information for the Interested Party on the conclusion of the insurance policy).

Article 11

Commencement and Duration of the Insurance – Insurance Period

1. The Insurance is concluded for a fixed Insurance Period from the commencement of the Insurance Period to the end of the Insurance Period. The Insurance Period is agreed in the insurance policy.

2. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Insurance Period, but no earlier than on the day following the day on which Insurance premiums were paid.

3. The Insurance lasts from its commencement until the actual expiration of the Insurance.

Article 12

Amendments to and Termination of the Insurance Policy. Expiry of the Insurance

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.

2. The insurance policy expires upon the expiry of the Insurance Period, i.e. at 24:00 hours on the day agreed as the date of the termination of the Insurance Period.

3. If the termination of the Insurance Period is delayed, as well as if the termination of the Insurance is caused by the insurable interest, on the date when the Insured Person dies or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.

4. The Policyholder, at the date of the Insurer receiving notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, on the condition that this notification is accompanied by a copy of the insured person's valid ID card that he/she is a participant of public medical insurance of the Czech Republic.

5. The Insurer or the Policyholder may terminate the Insurance in writing:
   a) within two months of the conclusion of the insurance policy.
   b) within three months of the service of the notification of the expiry of the Insured Event. A one-month notification period shall commence running upon the service of the termination of the Insurance, with the Insurance terminating upon the expiry of this period.
   c) within one month of the publishing of the notification that the Insurer, without the request of the Insured Person, is unable to carry on its insurance business has been withdrawn.

6. The Policyholder may terminate the Insurance subject to an eight-day notice period:
   a) within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit.
   b) within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer.
   c) within one month of the publishing of the notification that the Insurer, without the consent of the Insured Person, is unable to carry on its insurance business has been withdrawn.

7. If the Policyholder or the Insured Person breaches the duties stipulated in paragraph 1 or 2 of Article 17, then intentionally or through negligence, the Insurer shall be entitled to withdraw from the insurance policy if it can prove that it would have not concluded the insurance policy had the questions been answered truthfully and completely. The Policyholder shall be entitled to withdraw from the insurance policy if the Insurer breached the duty stipulated in paragraph 8 or 9 of Article 14. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that it learnt or ought to have learnt of a breach of a duty stipulated in paragraph 1 or 2 of Article 17 or in paragraph 8 or 9 of Article 14.

8. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the insurance policy.

9. The insurance policy may, in exceptional cases, be terminated by a written agreement of the contracting parties under the agreed conditions.

10. The insurance policy may be assigned only with the Insurer's consent.

11. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder's death or the date of the Disease of the Policyholder, as well as if the Insurer's notice given written notice to the Insurer within thirty days of the Policyholder's death or winding up that he is not interested in the duration of the insurance policy to the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his Death. However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.

12. The Insurer does not expire due to the termination of the Insured Person's stay in the Czech Republic prior to the expiry of the Insurance Period.

13. The insurance policy terminates upon the expiry of all Insurance cover.

Article 13

Premium

1. The premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer for the insurance policy. This is a Single Insurance Premium.

2. The premium is payable on the date of the conclusion of the insurance policy in the currency and the amount stated in the insurance policy.

3. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.

4. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the Insurer's notification of the refusal to pay the Insurance Benefit is received.

5. If the Insurance is terminated according to Article 12 of these Insurance terms and conditions as a consequence of the Policyholder's termination or as a consequence of a notification of the termination of the insurance policy that has been made to the public medical insurance of the Czech Republic within the Duration of the Insurance, the Insurer shall to the Policyholder, after calculating the total Insurance Benefit paid, but not later than five calendar days of the expiry of the Insurance, part of the premium corresponding to the unused premium as at the expiry of the Insurance, after deducting:
   a) the costs associated with taking out and maintaining the Insurance,
   b) the costs associated with the Insurance Benefits, and
   c) the amount corresponding to the pro-rata part of the Superior standard, by which the Insured Person would have been covered if the insurance policy had been concluded, as well as whether the other contracting party is entitled to a reduction in the case of paying the Insurance Benefits and losses caused by a third party.

6. If the premium is paid, the Insurer is entitled to the entire Single Insurance Premium paid.

7. If the insurance policy is terminated by agreement before the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with the insurance policy, by which the Insurer would have been covered if the insurance policy had been concluded, as well as whether the other contracting party is entitled to a reduction in the case of paying the Insurance Benefits and losses caused by a third party.

8. If the Insurer receives the premium after the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with the insurance policy, by which the Insurer would have been covered if the insurance policy had been concluded, as well as whether the other contracting party is entitled to a reduction in the case of paying the Insurance Benefits and losses caused by a third party.

9. If the premium is paid, the Insurer is entitled to the entire Single Insurance Premium paid.

10. If the Insurer receives the premium after the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with the insurance policy, by which the Insurer would have been covered if the insurance policy had been concluded, as well as whether the other contracting party is entitled to a reduction in the case of paying the Insurance Benefits and losses caused by a third party.

11. If the premium is paid, the Insurer is entitled to the entire Single Insurance Premium paid.

12. If the Insurer receives the premium after the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with the insurance policy, by which the Insurer would have been covered if the insurance policy had been concluded, as well as whether the other contracting party is entitled to a reduction in the case of paying the Insurance Benefits and losses caused by a third party.
1. If the Insurer asks the Interested Party in writing whilst the provisions contained in paragraph 1 of this article seeking out medical treatment, should the need arise, and the provisions about the Insurance Benefit shall be deemed received after the Insurer:

a) pay reasonable and demonstrable costs to the authorised service provider, 

b) collect the originals of the required documents and to store them safely until their submission to the Insurer, 

c) submit the required documents to the Insurer without undue delay.

Article 17

Other Rights and Obligations of the Parties to the Insurance

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst amending the amends the policy insurance about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.

2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.

3. Should an event occur with which the person who considers himself or herself to be a Beneficiary links his claim to an Insurance Benefit, he shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event, the name of the person involved if relevant to the Insurance Benefit, at the same time, he shall also submit to the Insurer the required documents and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have the duties.

4. The same notification may be made by any person with a legal interest in the Insurance Benefit.

5. The notification under paragraph 3 and 4 of this article shall be deemed received after the Insurer:
   I.) was notified of the event on the Insurer's form that has been duly completed,
   II.) was handed originals (unless stated otherwise hereinafter) of all the required documents or documents requested by the Insurer.

The required documents:

A) documents demonstrating:
   a) the cause, time, place and circumstances of the occurrence of the Insured Event, and the direct connection of the Insured Event with the Insurer in connection with this activity.
   b) a detailed specification of the subject of compensation (e.g. a medical report with the diagnosis, description and date of the procedures performed and the medicines administered).
   c) an extract of an act notarised on the basis of a prescription issued by the attending doctor) and detailing the date and amount of the prescribed medication (e.g. receipts on a cash payment, account statements).
   B) In the case of Insurance Benefits for Out-patient Medicines prescribed by a doctor, also copies of the prescriptions and in the case of the Insured Person, specifying the date of issue, the quantity and description of the medicines and healthcare aids, and the signature and stamp of the issuer.
   C) In the case of an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident.
   D) In the case of the death of the Insured Person, also a copy of an official death certificate and medical certification of the cause of death.

All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.

6. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit: at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.

7. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed, the Insurer is entitled to compensation for the costs it purposely incurred in investigating the facts in regards to which this information was given or concealed from him. It is understood that the investigation costs were incurred purposely.

8. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.

9. The Policyholder and the Insured Person are obliged:
   a) to notify the Insurer in writing at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy.
   b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required.
   c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Part.

Article 18

Delivery of Documents

1. Documents designated for the parties to the Insurance (hereinafter the "addressee") shall be delivered by the holder of a postal licence (hereinafter the "Post Office"), by ordinary or registered mail to the residential address or registered office stated in the insurance policy. Should the addressee give an address that is different to his residential address or registered office (hereinafter the "correspondence address"), delivery shall be made to this address, with the address correspondence, the correspondence address, should his residential address or registered office is in another place.

2. Correspondence sent by mail is deemed to be delivered on the third business day following dispatch. Correspondence sent to an addressee by registered mail with a delivery slip is deemed to be delivered on the date of receipt stated on the delivery slip.

3. Correspondence sent to an email address is deemed to be delivered on the day that it was delivered to the email box at the address of the addressee; in the event of doubts, it shall be understood that it was delivered on the date that it was sent by the sender.

4. Correspondence sent to a data mailbox is deemed to be delivered the moment it is logged on to the person who, in view of the extent of his/her authority, has access to the correspondence.

5. Documents of the parties to the Insurance may also be delivered via an emmissary by the Insurer or by other parties authorised by the Insurer; in these cases the document is deemed to be delivered on the date it is accepted.

6. If the addressee deliberately delays the delivery of a document, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.

7. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence, is it deemed to have been duly delivered on the date on which it was returned to the insurer.

8. The Insurer's or Policyholder's place of delivery is the address stated in the insurance policy.

Article 19

Rescue Costs

1. If the Policyholder purposely incurs costs in averting the immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, the Insurer shall be entitled to offset these costs from the indemnification for these costs from the indemnification the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.

2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit.

3. The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Policyholder.

3. Compensation for rescue costs is in excess of the framework of the agreed Insurance Benefit limit.

4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Article 20

Assignment of Rights to the Insurer

1. If a person entitled to the Insurance Benefit, the Insured or a person insured, has already incurred costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to compensation from another person with whom he lives in a joint household or is dependent on him, unless he caused the Insured Event intentionally.

2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all it is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.

3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become statute-barred.

4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party in consideration of the Insurer.

5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.

6. If, in connection with the exercise of the claim, the Beneficiary incurs additional costs due to the failure of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs.

Article 21

Assistance Service

1. The assistance services are the services provided to the Insured Person in connection with the Insurance cover taken out by the person providing this Insurance contract through the Insurer. The assistance services are provided 24 hours a day. Contact details for the assistance service provider are contained in the Insured Person's Card.

2. The assistance services are provided to the following extent:
   a) recommendation of a contractual healthcare facility, 
   b) arranging admission at a contractual doctor for treatment during office hours,
   c) recollection of an appointment procedure in the case of a Loss Event, 
   d) monitor developments in the medical condition during the course of hospitalisation, 
   e) provision of a liquidity guarantee to the contractual healthcare facility in the event of a claim for an Insurance Benefit, 
   f) ensuring the repatriation of the claimant in the event of a medical reason, 
   g) arranging for a professional companion in the context of repatriation, 
   h) arranging for the transportation of the remains in the event of death.

Article 22

Final Provisions

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.

2. The language of communication is Czech.

3. Persons with restricted legal capacity shall be represented by their legal guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.

4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.

5. The Insurer's costs associated with taking out and administering the Insurance come to 20% of the unearned premium.

6. All disputes arising out of or in connection with this Insurance with which the Insurer is not - not - involved, are to be settled in the courts of the Czech Republic in compliance with Czech law.