GENERAL TERMS AND CONDITIONS OF
VOLUNTARY HEALTH INSURANCE

Pursuant to Article 15 and 16 paragraph 1 of the Decree on Voluntary Health Insurance (Official Gazette of the Republic of Serbia No. 108/08 and 49/09) and Article 11.2.1. and Article 11.3.2., of the Articles of Association of Wiener Städtische Insurance a.d.o. Beograd, the Managing Board of Wiener Städtische Insurance a.d.o. Beograd, at its sitting held on 28. June 2016, made out

GENERAL TERMS AND CONDITIONS OF VOLUNTARY HEALTH INSURANCE

INTRODUCTORY PROVISIONS

Article 1.

General Terms and Conditions of Voluntary Health Insurance (hereinafter: General Terms) are a constituent part of the contract on concurrent, additional, private and a combination of concurrent and additional health insurance of persons (hereinafter: Insurance Contract), which the insurance Policy Holder has concluded with Wiener Städtische Insurance a.d.o. (hereinafter: Insurer).

These General Terms regulate the rights and mutual liabilities of the contractual parties in the procedure of application form filing and stipulation of the voluntary health insurance, insurance duration, general provisions of the insurance premium, as well as conditions under which certain rights, scope of coverage and other terms of significance for the voluntary health insurance are exercised.

Any notices and applications which the contractual parties are obliged to make in view of the provisions of General Terms have to be obligatorily confirmed in writing provided that they have been made orally, by phone or in some other manner.

As the receipt day of a notice or application shall be deemed the day when Insurer and/or Policy Holder has received the notice and/or application.

If the notice and/or application are sent by registered mail, the day of delivery at the post office shall be deemed as the receipt day.

The agreements relating to the contents of the insurance contract shall be valid only if made in written form.

MEANINGS OF USED TERMINOLOGY

Article 2.

Meanings of certain concepts used in General Terms:

Insurer:
Wiener Städtische Insurance a.d.o. Belgrade;

Policy Holder of Voluntary Health Insurance (hereinafter: Policy Holder):
Legal or natural person as well as any other legal subject who, on behalf and for account of the Insured and/or on one’s own behalf and for account of the Insured, has concluded the Contract on voluntary health insurance with Insurer and who has taken over the obligation of paying the insurance premium out of own means or on the account of the Insured;

Applicant:
The person who files the written application form for conclusion of the contract on voluntary health insurance to Insurer;

Insured:
Natural person who has concluded a contract on voluntary health insurance or on whose behalf, based on his/her consent, the contract on voluntary health insurance with Insurer has been concluded and who exercises the rights determined by the contract on voluntary health insurance;

Application Form:
A written proposal by Applicant sent to Insurer for conclusion of the insurance contract;

Policy:
The document of concluded contract on voluntary health insurance with Insurer;

Insurance Premium:
A money amount that the Insured and/or Policy Holder pay to Insurer on the basis of the concluded contract on voluntary health insurance;

Collective Insurance:
Voluntary health insurance concluded by Policy Holder with Insurer, who has been chosen in accordance with the Law, about what Policy Holder and Insurer may conclude the contract on voluntary health insurance;

Health Services:
Services provided in health institutions and other forms of health service (hereinafter: private practice), in compliance with the Law governing health protection, for exercising health protection, and/or exercising the measures for preservation and promotion of the health of people, prevention, suppression and early detection of diseases, injuries and other disorders of health, treatment and rehabilitation, including health services from traditional medicine, which are safe, of high-quality and efficient.

Health Institution:
A legal person which conducts health activity and which has obtained the permit from the ministry competent for health activities (hereinafter: Ministry)
for performance of health activity in accordance with the Law governing health protection and the regulations passed for exercising that Law.

Private Practice: Another form of health service were certain jobs from health activity are conducted and which has obtained the permit from the Ministry for performance of certain jobs from health activity in accordance with the Law governing health protection and the regulations passed for exercising that Law.

Other providers of health services: Other legal or natural persons who conduct certain jobs from health activity and/or provide medical technical aids and who have obtained the permit from the competent authority for performance of such jobs in accordance with the Law.

Medicine: A product that contains a substance or a combination of substances manufactured and dedicated for treatment or prevention of diseases in people, making a diagnosis, improvement or change of physiological functions, as well as for achievement of other medically justified objectives and which was granted a permission for putting in free trade in the Republic of Serbia, as well as the product which has not been granted a permission for putting in free trade in the Republic of Serbia but which is imported based on the approval of the Medicines and Medical Devices Agency of Serbia in compliance with the Law governing the field of medicines.

Medicine Technical Aids: Medical aids used for functional and aesthetic replacement of the lost parts of the body, and/or for enabling support, prevention of occurrence of deformities and correction of the existing deformities and facilitation of performance of the basic vital functions.

Implants: Medical devices implanted into a human organism by surgical intervention.

Money Compensations: The compensations which Insurer provides to the Insured in the case of loss of income and/or salary or other earnings due to temporary prevention for work, compensation for costs of transport related to the use of health protection as well as other kinds of subsidies in relation with exercising the rights from voluntary health insurance.

Insured Sum: Money amount of the compensation which represents the maximal liability of Insurer according to the concluded insurance contract.

Insured Event: Event by which occurrence arises the liability of Insurer to pay the compensation from insurance.

Waiting Period: The period at the beginning of insurance duration when Policy Holder pays the insurance premium and Insurer has no liabilities if the insured event occurs.

Certificate on Voluntary Health Insurance: The document issued to the Insured by Insurer on the basis of which the Insured proves his/her capacity of the insured person of voluntary health insurance and exercises the rights from voluntary health insurance.

CLASSES OF INSURANCE

The classes of voluntary health insurance exercised by Insurer are:

1. Collateral health insurance is the insurance covering the expenses of health protection which occur when the insured exercises health protection comprised by the mandatory health insurance in the manner and according to the procedure which are different from the manner and procedure for exercising the rights from mandatory health insurance in accordance with the General and Special Terms and Conditions of Insurer;

2. Additional health insurance is the insurance covering the expenses of health services, medicines, medical technical aids and implants, and/or money compensations which are not comprised by the rights exercised from the mandatory health insurance, namely, the Insured is provided with insurance of greater contents, scope and standard of rights as well as money compensations than those comprised by the mandatory health insurance in compliance with the General and Special Terms and Conditions of Insurer;

3. Private health insurance is the insurance of persons who are not comprised by the mandatory health insurance or who have not joined the mandatory health insurance for coverage of expenses for the kind, contents, scope and standard of rights stipulated with Insurer;

4. Combination of concurrent and additional health insurance.

ACQUIRING A CAPACITY OF THE INSURED

The capacity of the Insured in concurrent and additional voluntary health insurance may be acquired by a person who has a capacity of the insured person in mandatory health insurance of the Republic of Serbia and who expresses an explicit intention to conclude with Insurer the contract on concurrent and/or additional health insurance as well as a combination of concurrent and additional health insurance according to these General and Special Terms and Conditions of Insurer.

The capacity of the Insured in private voluntary health insurance may be acquired by a person who does not have a status of a mandatory
health insured person and who expresses an explicit intention to conclude with Insurer the contract on private health insurance according to these General and Special Terms and Conditions of Insurer.

CONCLUSION OF THE CONTRACT

Article 5.

The contract shall be concluded on the basis of written application form which the person who wishes to conclude the insurance contract (Applicant) files to Insurer on the printed form of Insurer.

In the case of collective insurance, Policy Holder may file a unique application form containing details about each person who wishes to be insured by Insurer.

Insurance of several persons by one Policy Holder per one policy may be stipulated only under condition that all insured persons have the same coverage level.

All details necessary for conclusion of the insurance contract as well as all facts of significance for risk assessment have to be stated accurately, truly and in full in the application form.

The constituent part of the application form in insurance is the Questionnaire on Health Condition of the Insured on the printed form of Insurer.

Upon receipt of the application form for conclusion of the contract, Insurer may require from the potential Insured some additional information about health condition and/or require from him/her to present documentation (medical or laboratory results and reports) or if necessary to have a medical examination.

Insurer shall make risk assessment for every Insured separately and/or shall be entitled to admit the person for whom it is determined to present an increased risk in insurance against premium increase.

Further provisions on increased risks are comprised by Insurer's Special Terms and Conditions.

The application form filed to Insurer for conclusion of the insurance contract shall bind the Applicant for the period of eight days, unless he/she has set a shorter term, from the day when Insurer has received the application form, and/or 30 days, if medical examination is necessary.

It shall be deemed that Insurer has received a written application form on the day when it has been officially recorded in any organizational part of Insurer.

In the case that after having received the application form Insurer requires additional data in accordance with paragraph 6 of the Article herein, namely, if medical examination of the potential Insured has to be carried out, the application form shall be deemed as received when Insurer has received the additional data and/or the required medical reports upon performed medical examination.

Provided that upon Insurer's written requirement the applicant does not furnish the required evidence within eight days counting from the receipt day of Insurer's written requirement for delivery of required evidence, it shall be deemed that the applicant has desisted his/her application form and/or conclusion of the insurance contract.

The received medical evidence about potential insured person cannot be the reason for refusal of admission into insurance but shall be used by Insurer for risk assessment in order to calculate the insurance premium.

DURATION OF THE INSURANCE CONTRACT

Article 6.

According to the General Terms, the insurance contract shall be concluded for the period that cannot be shorter than 12 months counting from the day of contract conclusion except in the case when the Insured's capacity of an insured person has ceased in accordance with regulations from mandatory health insurance.

Article 7.

Liabilities of Insurer shall start from the twenty-fourth hour of the day designated in the insurance policy as the commencement day of voluntary health insurance under condition that insurance premium and/or insurance premium installment has been paid until the end of the last day of the time-limit for which the insurance was agreed and which is designated in the insurance policy.

It shall be also deemed that the first agreed insurance premium is paid when Policy Holder and/or Insured have given a written statement on the basis of which charging for the premium is executed via suspension from his/her earnings.

Provided that the first agreed insurance premium is not paid until the day designated in the policy as the commencement day of insurance duration, the liability of Insurer shall start on the twenty-fourth hour of the day when the first agreed premium has been paid in full.

Provided that the waiting period is agreed, the liability of Insurer shall start on the twenty-fourth hour of the day designated as the expiration day of the waiting period under condition that the first insurance premium has been paid.

Article 8.

The insurance contract for each individual insured person shall cease at 24.00 hours regardless of the agreed duration in the case of:
- Death of the Insured - the day of death;
- Loss of the insured person status in the mandatory health insurance - the day of the status loss;
- Premium non-payment;
- Other cases in accordance with regulations, General and Special Terms and Conditions of Insurer.

WAITING PERIOD (CADENCE)

Article 9.

The waiting period is the period at the beginning of insurance duration when Policy Holder pays the insurance premium whereas Insurer has not liabilities if the insured event occurs.

Waiting periods shall not apply in case of the insurance contract renewal.
INSURANCE PREMIUM

Article 10.

The height of insurance premium shall be determined by Insurer in accordance with the insurance tariff (hereinafter: Tariff) and the rules governing the field of voluntary health insurance.

Insurer cannot increase the insurance premium height within the period for which the contract on voluntary health insurance has been concluded.

Exceptionally from paragraph 2 of the Article herein, in the case of contracts concluded for a period of several years the insurance premium may be changed upon expiration of the period of 12 months from the day of the contract on voluntary health insurance conclusion, namely at every 12 months until expiration of the term for which the insurance contract has been concluded.

The policy holder shall be obliged to pay the insurance premium to Insurer regularly on due date, within terms of payment agreed by the contract and/or insurance policy.

Provided that payment of the annual premium in semi-annual, quarterly or monthly installments has been agreed, Insurer shall be entitled to the insurance premium for the entire year of insurance duration.

Exceptionally from paragraph 5 of the Article herein, in the case of insurance cessation due to death of the insured, Insurer shall appertain the insurance premium until the day the insurance has lasted.

Insurer shall be entitled to charge Policy Holder with the legal default interest for every day of break-over of the term when he is obliged to settle the matured insurance premium.

The first agreed insurance premium and/or the first installment shall be payable until the day of the insurance contract commencement.

Every subsequent insurance premium installment shall be payable on the last day of the current time period (semi-annual, quarterly, monthly) for the subsequent time period.

Payment of the outstanding premium installment shall always refer to the first unpaid insurance premium while Insurer shall be entitled to charge the outstanding matured premiums and default interest at the occasion of any payment on the grounds of the subject insurance contract.

It shall be deemed that the insurance premium is paid on the day when payment has been recorded on the account of Insurer.

Insurer shall be obliged to accept the paid insurance premium from any person who has legal interest that the insurance premium is paid.

DOCUMENT FOR EXERCISING THE RIGHTS FROM INSURANCE

Article 11.

Insurer shall be obliged to issue a document to every insured on the basis of which they exercise the rights from the voluntary health insurance (hereinafter: Document) on the day of insurance policy issuance but not later than 60 days.

The document shall be issued for the period of insurance duration.

The document shall be valid under presentation of identification card or some other identification paper of the Insured.

The Insured shall be obliged to report the loss of the document in writing without postponement to the technical service of Insurer in charge of voluntary health insurance. In that case, Insurer shall be obliged to issue a duplicate of the document with collection of additional costs.

RISKS COVERED BY INSURANCE

Article 12.

The insured event represents an event when the Insured due to health disorder (disease or injury) has been exposed to a medically justified treatment (health service, medicines, medical technical aids, implants, etc.) which is the subject-matter of the insurance contract and whose expenses have to be defrayed to the health institution, private practice, other providers of health services or the Insured.

Provided that the insured event occurs in view of these Terms, Insurer shall be obliged to compensate to the Insured the standard and regular expenses up to the agreed coverage height that occur in the course of the insurance contract duration in respect of medically justified treatment exercised to the Insured.

Apart from paragraph 2 of the Article herein, provided that the insured event occurred prior to the commencement of the insurance coverage and treatment according to that insured event has been underway even after the commencement of the insurance coverage, Insurer shall not be obliged to bear the costs incurred during such a treatment.

The insured event shall in any case end by expiration of the insurance contract in accordance with the General Terms.

Article 13.

The insurance coverage height as well as liabilities of Insurer according to the insurance contract shall be determined by Insurer’s separate terms.

The insured sum designated in the insurance policy shall be the maximal liability of Insurer in accordance with the concluded contract.

The insurance coverage shall be valid 24 hours a day during the agreed insurance duration at the territory of the Republic of Serbia unless otherwise prescribed by some special terms.

PARTICIPATION OF THE INSURED IN TREATMENT EXPENSES

Article 14.

Policy Holder and Insurer may determine by the contract the participation of the insured in every damage and/or expenses of health services in appropriate amount or percentage.

In that case, the Insured shall participate with appropriate percentage or amount in the damage in such a manner that the amount of the agreed participation of the Insured is deducted from the total amount of Insurer’s liability.

Provided that the occurred damage is less than the agreed participation, Insurer shall have no liability in regard of compensation payment up to the amount of the agreed participation.
The agreed participation of the Insured in the damage shall apply for each insured event which occurs in the course of the insurance duration.

INSURER’S LIABILITIES

Article 15.

Insurer shall be obliged to enable the insured persons of the voluntary health insurance to exercise the rights determined by the contract on voluntary health insurance as well as the rights determined by Insurer’s General and Special Terms and Conditions.

According to the insurance contract and/or policy and Special Terms, Insurer shall be obliged to compensate to the provider of health services or the Insured the expenses or part of the expenses incurred by exercising the rights from the voluntary health insurance as well as the amount of the agreed money compensations within 14 days from the day when complete documentation has been received on the grounds of which existence and scope of liability can be determined beyond dispute.

Article 16.

Insurer shall not be obliged to pay the compensation from insurance in the following cases:

- If the insured gave incorrect and untrue data and/or suppressed important circumstances of significance for conclusion of the insurance contract;
- If neither Policy Holder and/or Insured pay the matured insurance premium until the agreed time-limit nor some other person does it instead;
- In the case of insurance policy and/or document abuse;
- If the scope of agreed health services and expenses height has been exceeded;
- If the compensation claim is based on false data and false documentation.

LIABILITIES OF POLICY HOLDER AND INSURED

Article 17.

Except for the liabilities established by the regulations governing the field of voluntary health insurance and Insurer’s General and Special Terms and Conditions:

1. the Insured shall be obliged to present the document for inspection to the health institution, private practice and/or other providers of health services at the occasion of exercising the rights from voluntary health insurance;
2. Policy Holder and/or Insured shall be obliged to inform Insurer within the shortest reasonable time about all changes of the data relating to the insured persons (such as change of address, job or marital status, employment cessation, etc.) or about any other important changes such as the change of the number of insured persons, which affect correction of insurance risk assessment.

TERMINATION OF THE INSURANCE CONTRACT

Article 18.

Provided that neither Policy Holder nor any other interested person pay the matured premium until the agreed time-limit, the insurance contract shall cease by expiration of the 30th day from the day when Policy Holder has received the registered letter from Insurer with a notice about the insurance premium maturity, but under condition that that time-limit cannot expire prior to expiration of 30 days from the premium maturity day.

In any case, the insurance contract shall cease by Law if the premium is not paid within a year from the maturity day.

Provided that the Insured has filed an incorrect application or concealed any circumstances of such nature that Insurer would not have concluded the contract under the same conditions if the real state of affairs had been known, Insurer may request the contract annulment.

CANCELLATION OF THE INSURANCE CONTRACT

Article 19.

Every contractual party may cancel the insurance contract with indefinite duration unless the contract has been cancelled on some other grounds.

The cancellation shall be done in writing not later than three months from expiry of the current insurance year.

Provided that insurance has been concluded for a period longer than five years every party may, when the agreed term has elapsed, with a six-month termination notice, notify another party in writing that it shall cancel the contract.

COMPLAINT OF THE INSURED

Article 20.

The Insured who is not satisfied with the decision of Insurer against the compensation claim may file a complaint to Insurer’s Complaints Committee within eight (8) days from the day of decision receipt.

DETAILS ABOUT THE INSURED PERSONS

Article 21.

Policy Holder and the Insured shall authorize Insurer to collect, check, process, store and use personal data necessary for contract conclusion in accordance with the Law on personal data protection.

Insurer shall be obliged to keep the data from paragraph 1 of this Article as a business secret in accordance with the Law.

At the conclusion of the contract, Insurer shall not ask for the genetic data and/or results of genetic tests for certain hereditary diseases of the person who expresses an explicit intention to conclude the contract nor his relatives regardless of the line or level of kinship.

THE RIGHT TO RECOURSE

Article 22.

The rights of the insurance Policy Holder and/or Insured towards the third party who is liable for the damage shall be transferred to Insurer in the height of the compensation paid by Insurer without obtaining any special consent from the Insured.

For exercising the right of recourse in view of paragraph 1 of this Article, the insured person shall be obliged to provide the evidence to Insurer related to the concrete case and which Insurer asks for from him/her.

Costs of obtaining this evidence shall be borne by Insurer.

Provided that Policy Holder and/or Insured receive compensation from the third party responsible for damage, Insurer shall be entitled to deduct that amount from the compensation to be paid to the Insured on the grounds of occurred insured event in accordance with the insurance contract.
PROCESSING AND STORING OF PERSONAL DATA

Article 23

The insurer processes the data on the policyholder/insured for the purpose of realization of the insurance contract and fulfillment of the obligations stipulated by the valid regulations.

The policyholder/insured has the right to be informed about the information that the Insurer keeps about him/her and has the right and obligation to require the Insurer to correct, complement and update the data relating to him.

Data on the policyholder/insured may be used by employees of the Insurer, as well as employees of other persons and/or institutions to whom the Insurer provides the information in accordance with legal regulations or contractual obligations.

The policyholder/insured is entitled to revoke his/her consent to the processing of data for other purposes, except for the purpose of concluding and fulfilling the contract. In case the policyholder/insured wishes to revoke his/her consent, he/she is obliged to inform the Insurer in writing. The insurer is obliged, after receiving the notification from the policyholder/insured about the revocation of approval for other purposes, except for the purpose of concluding and fulfilling the contract, to delete the information about him/her.

With its signature on the offer for conclusion of the insurance contract/policy or other document, the policyholder/insured confirms that he/she has been informed and agrees with the above, and the consent given in this way, represents the legal basis for the Insurer for processing and collecting personal data of the policyholder/insured, in accordance with the provisions of the Law on Personal Data Protection.

TRANSITIONAL AND FINAL PROVISIONS

Article 24.

General Terms may be changed in regard of the procedure and manner they have been passed.

For the insurance contracts which are under course until expiry of the insurance year shall be subject to General Terms on the basis of which these contracts were concluded, except if the conditions were changed due to legislation changes to which Insurer had no influence.

If Insurer changes General Terms it shall be obliged to notify Policy Holder and/or Insured with whom it has the concluded contract on perennial insurance accordingly in writing as well as in any other appropriate manner (daily newspapers, radio, television, Insurer's web site, etc.).

Policy Holder shall be entitled to cancel the insurance contract within 30 days from the day of receipt of the notification from paragraph 3 of this Article. In that case, the contract from paragraph 2 of this Article shall cease by expiration of the current insurance year.

Provided that Policy Holder does not cancel the insurance contract within the term from paragraph 4 of this Article, the insurance contract shall be renewed in accordance with the changes made in the General Terms of insurance. Policy Holder may notify Insurer until the commencement day of application of the new General Terms that he/she cancels the insurance contract in which case the insurance contract shall cease as of the day of application of the new General Terms. Otherwise, the concluded contract shall be subject to the new General Terms.

Article 25.

The outstanding from the contract shall expire according to the provisions of the Law on Torts and Contracts.

Article 26.

The contractual parties shall settle any disputable issues agreeably, whereas provided that they do not come to an agreement, they shall negotiate the competence of the really competent court according to Insurer's head office.

Article 27.

All relationships of the contractual parties which are not regulated by these Terms directly shall be subject to the provisions of the Law on Torts and Contracts and the rules governing voluntary health insurance.

Article 28.

These terms and conditions shall come in force on the first subsequent day after their publication according to the Insurer’s Articles of Association.

On the day these terms and conditions come to force, General terms of voluntary health insurance issued on 06. November 2015. will not be valid.