EXPATRIATE CARE INSURANCE

TERMS AND CONDITIONS

001-2022

COLONNADE
A FAIRFAX COMPANY

INTRODUCTION

This policy is a contract between the policyholder and Colonnade Insurance S.A. Branch Office in Hungary.

The Company agrees to give the insurance cover set out in this policy under the sections (and subsections) of cover that are shown as being included on the Schedule. This policy, the Schedule and all attached memoranda and endorsements detail the entire cover provided and the terms and conditions applying to it.

The Company will only provide cover for those people who are shown as being insured on the Schedule and/or have been enrolled on the platform of the Medical Plan Administrator, or any attached memoranda or endorsements for the period of insurance as long as the required premium has been paid and the Company has accepted it.

The policyholder should read this policy to make sure that they understand the cover provided and the limitations applying. If there are any elements of the cover that require clarification or do not meet the needs of the policy holder, the policy holder should in the first instance raise these with their insurance intermediary, where applicable.

1. ARTICLE 1 – GENERAL DEFINITIONS

The following definitions apply to the policy, and have the same meaning wherever they are used in the policy, policy schedule or endorsements.

1.1 **Accident** means a sudden, violent external event which results directly and immediately in Injury to the Insured Person, and which may or may not result in death, provided that the nature and location of the Injury or the cause of death can be medically established.

Accident shall also be taken to mean:

a) Health disorders that are directly and solely due to an insured Accident;
b) Injury resulting from lawful self-defense, or rescue or attempted rescue of endangered persons or goods;
c) Acute and unintentional ingestion of solid, liquid and/or gaseous substances that are injurious to a person's health.
d) Dislocations, sprains, muscle strains or ruptures caused by a sudden exertion;
e) Disorders due as a result of extreme weather conditions;
f) Drowning;
g) Rabies or tetanus as the result of an insured Accident;
h) Death of the Insured Person as a result of a traffic Accident, due to cardiac arrest, myocardial infarct or cardiac artery rupture of the Insured Person.

1.2 **AIDS/HIV**

Human Immunodeficiency Virus ("HIV") related Illnesses including Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex and/or any mutation, derivation, or variation thereof which occurs during the period of insurance of this policy or any subsequent renewal of this policy and manifests itself at any time after the Effective Date of this policy.

1.3 **Area of Cover**

The policy covers the Insured Person within his Area of Cover as mentioned in the policy schedule.

Cover outside the Insured Person's Area of Cover is limited to emergencies in case of leisure or business travel, taking place during the Benefit Period and lasting no longer than 90 consecutive days, and excluding any travel if the purpose of the trip is to obtain medical treatment or medical advice or in case the Insured Person is traveling against the advice of a Physician.

1.4 **Assistance Centre** means the organization that provides the assistance services described in this policy on behalf of the Company.

1.5 **Colonnade Atlasz Assistance** means the organization that provides the assistance services described in this policy on behalf of the Company.

1.6 **Automobile** means a land motor vehicle, trailer or semi-trailer. The term does not refer to crawler or farm-type tractors or farm equipment nor to any other equipment which is designed for use primarily away from public streets or highways and which is not subject to motor vehicle registration.

1.7 **Bodily Injury** to the body caused by an Accident which occurs during the Period of Insurance and not by any gradual cause. It does not include:

- Sickness, unless this results from injury to the body;
- post-traumatic stress disorder; or
- a psychological or psychiatric illness or condition except and incurable insanity where such condition is a direct consequence of an Accident

1.8 **Beneficiary** means the person who is designated as such in the policy; in the absence thereof:

- In the event of death: the legal heirs with the exclusion of the Sovereign State;
- In all other cases: the Insured Person.

1.9 **Benefit Period** means the period between the Effective Date of the cover and the termination of the benefits (Point 2.4) for the concerned Insured Person.

1.10 **Business Property** means property on which a business is conducted; and property rented in whole or in part to others, or held for such rental by the Insured Person.
It does not include the Insured Person's residence if it is rented only occasionally; or if it is a two family dwelling usually occupied in part by the Insured Person. It does also not include garages or stables, if not more than 3 car spaces or stalls are so rented or held for rental.

1.10.1 **Company** or **Insurer** ***means*** Colonnade Insurance S.A. Branch Office in Hungary (99. Váci út, Budapest, H-1139; Company registration number: Registry Court 01-17-000942; Phone number: +36 1 460 1400; Mailing address: 153 Pf., Budapest, H-1426, Hungary). Founder of Colonnade Insurance S.A. Branch Office in Hungary: Colonnade Insurance S.A. (1, Rue Jean Piret, L-2350 Luxemburg), registered by Registre de Commerce et des Sociétés, Luxemburg, register number: B 61605, licence issued by Grand-Duche de Luxemburg, Minister des Finances, Commissariat aux Assurances (L-1840 Luxemburg, Bureaux: 7, Boulevard Joseph II.) licence number: S 068/15.

Please find the annual report covering their financial situation and solvency on our website: www.colonnade.hu/rolunk.

1.11 **Competent Supervisory Authority**
National Bank of Hungary (Magyar Nemzeti Bank)

1.12 **Complementary Medicine** means consultation services and medication provided by a physiotherapist, chiropractor, acupuncturist, bonesetter, osteopath, homoeopath or Chinese medicine practitioner, who is fully trained, who is licensed by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his or her licensing and graduation.

1.13 **Complications of Pregnancy** are conditions whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. They include ectopic pregnancy which is ended, spontaneous ending of pregnancy at a time when a viable birth is not possible, puerperal infection, eclampsia, and toxemia. They do not include complications or Illness from IVF induced pregnancy, caesarean section, false labor, occasional spotting, Physician prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy, but which are not medically distinct conditions.

1.14 **Congenital Condition** means a physical or mental abnormality existing at time of birth or manifesting itself within six months of birth.

1.15 **Co-Payment** means the share of the Covered Charges the Insured Person will pay, after application of Deductible if any. This is usually expressed as a percentage.

1.16 **Cosmetic Surgery** means any treatment performed to reshape normal structures of the body in order to improve the physical appearance.

1.17 **Covered Charge** means a reasonable and customary charge for a Medical Necessary service prescribed by a Physician.

1.18 **Date of Service** means the date on which a medical service is rendered.

1.19 **Deductible** means an amount stipulated in the schedule which shall be deducted from any Covered Charges, before application of the Co-Payment, if any.

1.20 **Dependant** means an Insured Person who is the adult partner, dependent child or child under 23 years in full-time education of the Expatriated Employee and who is residing with him in the Host Country.

1.21 **Effective Date** means the date on which the period of cover commences for the Insured Person under this policy.

1.22 **Emergency** means a sudden change in a person's health which requires urgent medical or surgical intervention to avoid permanent damage to life or health.

1.23 **Expatriated Employee** means an Insured Person who is an employee of the Policyholder and who is on an expatriate assignment on behalf on the Policyholder.

1.24 **Home Country** means the country of which the Insured Person holds a passport and to which the Insured Person would want to be repatriated. For an insured child holding more than one passport, the Home Country will be the Home Country of an Insured parent.

1.25 **Hospital** means an establishment duly constituted and registered as a facility for the care and treatment of sick or injured persons as paying bed patients and which:

a) has organized diagnostic and surgical facilities,
b) provides 24 hour a day nursing services by Registered Nurses,
c) is supervised by a staff of Physicians, and
d) is not a nursing home, rest home, convalescence home, place for custodial care, home for the aged, institution for Mental or Behavioral Disorders, sanatorium, or a place for the treatment of alcoholics or drug addicts; even if located at the same place.

1.26 **Hospitalisation** means admission in a Hospital as a registered bed patient for an overnight stay upon the written advice from the Physician and for which the Hospital imposes a room and board charge.

1.27 **Host Country** means the country where the Insured Person is expatriated to.

1.28 **Illness** means a physical condition marked by a pathological deviation from the normal healthy state, and which is not an Injury.

1.29 **Injury** means physical damage arising wholly and exclusively from a covered Accident.

1.30 **Insured Person** means every person designated as such in the policy schedule, who has applied for cover by this policy and for whom coverage has been confirmed in writing by the Company or the Medical Plan Administrator.

1.31 **Insured Premises** means the habitable premises where the Insured Person resides in his Host Country. It includes private approaches to such residence; and other premises and approaches used in connection with such residence, other than Business Property and farms.

1.32 **Legal Expenses** means

- The fees, expenses and other costs that can reasonably be charged by the Representative in connection with a cause for action, including the reasonable expenses of experts and of the Company incurred in this connection.
- The legal costs incurred by or on behalf of the Insured Person and the extra-judicial costs after settlement out of court.
- The fees, expenses and other costs that can reasonably be charged by the Representative for appeal proceedings, provided that prior written permission from the Company has been obtained for such proceedings and provided that they are connected with the cause of action referred under the first bullet point of this definition.

1.33 **Medical Consultant** means a Physician advising the Company, Assistance Centre or the Medical Plan Administrator.

1.34 **Medically Necessary** means for therapeutic services that the Insured Person has a covered Illness or Injury and that the services are requested by the attending Physician to prevent permanent damage to life or health.

For diagnostic services, Medically Necessary means that the Insured Person has active symptoms of unknown cause and suggestive of a covered Illness or Injury, and that the services are requested by the attending Physician to determine whether therapeutic services are required.

1.35 **Medical Plan Administrator** means the organization that provides the medical administration services described in this policy on behalf of the Company.

1.36 **Medicines and Drugs** are those for which a Physician's prescription is required for purchase, which have been prescribed by a Physician for treatment of a covered Illness or Injury, and which have been dispensed by a Physician's office or by a licensed pharmacist.

1.37 **Mental and Behavioral Disorder** means a psychiatric, psychological, affective, mental or behavioral disorder, irrespective of whether a physiologic cause is known or suspected. It includes any condition listed as Mental and Behavioral Disorder in the International Classification of Diseases of the World Health Organization.

1.38 **Operative Time** is the period of time during the Period of Insurance during which the Policyholder or an Insured Person is covered by this policy (as outlined in the Schedule and described later in this policy wording).

1.39 **Outpatient Surgery** means the surgery that does not require an Overnight Hospital stay, but may require the use of a recovery facility for at least 4 hours. Surgery shall mean treatment by incisions or shockwaves or lasers, including endoscopic procedures requiring the professional services of a qualified Physician or surgeon.

1.40 **Overnight** means an inpatient admission before 7pm with release no earlier than 8am the following morning.

1.41 **Palliative Care** means the services prescribed by the attending Physician, of an institution duly constituted and registered to provide a centralized program of palliative and supportive services to dying persons in the form of physical, psychological, social and spiritual care.

1.42 **Parental Accommodation** means costs for an added bed in the same room for a parent or legal guardian.

1.43 **Period of Insurance** is the period shown in the Schedule.

1.44 **Physician** means a medical practitioner graduated from a recognized medical school listed in the Directory of Medical Schools of the World Health Organization, who is licensed by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his licensing and graduation.

1.45 **Policyholder** means the person who has taken out this insurance with the Company and who is named as such in the policy schedule.

1.46 **Post-hospitalization Services** mean medical services immediately following a covered stay in a Hospital, and that are provided by or ordered by the attending Physician as a direct consequence of the covered Illness or Injury which necessitated such hospitalization.

1.47 **Preceding Policy** means an expatriate healthcare policy covering Illness and Injury which terminates no earlier than the day prior to the Effective Date for the Insured Person, and a copy of which has been provided to the Company upon application.

1.48 **Pre-hospitalization Services** mean medical services incurred within 30 days prior to and directly related to a covered stay in a Hospital which are provided by or ordered by a Physician.

1.49 **Reasonable and Customary Expenses** mean insured medical expenses which do not exceed the general level of fees for comparable services by similar healthcare providers in the same region for a similar Illness or Injury, irrespective of availability of insurance. In case of an unusual nature of service or supply, the Medical Plan Administrator will determine to what extent the charge is reasonable and customary, taking into account the complexity involved, the degree of professional skills required and other pertinent factors.

1.50 **Reconstructive Surgery** means any treatment performed on abnormal structures of the body, whether caused by Congenital Conditions, developmental abnormalities, Injury or Illness, in order to improve function or approximate a normal appearance.

1.51 **Registered Nurse** is a graduate trained nurse who has passed a state registration examination and has been licensed to practice nursing.

1.52 **Representative** means a licensed attorney or similar professional who has been authorized to act on behalf of the Insured Person in accordance with the conditions of this insurance policy.

1.53 **Residence Employee** means an employee of an Insured Person whose duties are incidental to the Insured Premises or who covers duties elsewhere of a similar nature and not associated with the conduct of an Insured Person's business.

1.54 **Sickness** means any fortuitous bodily illness or sickness, diagnosed during the Period of Insurance.

1.55 **Schedule** means the document showing details of the period of insurance, insured persons, included policy sections and the sums insured which should be read with this policy.

1.56 **Sound Natural Tooth** means a tooth with no decay, no filling on more than two surfaces, no gum disease associated

with bone loss, no root canal therapy, that is not a dental implant and that functions normally in chewing and speech.

1.57 **Standard Private Room** is the lowest rated room with a single bed in that Hospital.

1.58 **Terrorism:** is an act, including threats of or actual force or violence by, of any person or group of persons, whether acting alone or on behalf of or in connection with any organisation or Government, committed for political, religious, ideological or ethical purposes or reasons including the intention to influence any government and/or to put the public or any section of the public in fear.

1.59 **Venereal Disease** means an Illness which has been transmitted by sexual contact, or any of the following Illnesses whether sexually transmitted or not: syphilis, gonorrhea, venereal warts including genital HPV (human papillomavirus), genital herpes, granuloma inguinale, chancroid, trichomona, pubic lice (phthirus pubis) infestation, and Chlamydia.

1.60 **War** means any activity arising out of military force or an attempt to participate in military force by a nation, and will include civil war, revolution and invasion.

2. ARTICLE 2 – GENERAL CONDITIONS

2.1 Obligation to provide information

At the time of concluding the contract, the Policyholder shall provide information about the circumstances he knew or should have known, which is relevant in respect of undertaking the insurance.

2.2 Policy Period

The insurance policy shall take effect on the date stated in the policy schedule and continue for a fixed period of 12 months. The policy is tacitly renewed on each expiry for a period of 12 months unless the Company or the Policyholder cancels the policy by registered letter at least 30 days before the end of such period.

2.3 Eligibility

The policy is open to employers located in the European Economic Area to cover their Expatriated Employees and their Dependants, while on foreign expatriate assignment outside their Home Country. The age limit for enrolment of an Insured Person is 65 years.

The Effective Date of the cover is the day immediately following the acceptance by the Company of the completed application form and, based on the medical formalities, the acceptance by the Medical Consultant of the Company.

The medical formalities are:

- *In case of compulsory affiliation by the employer of a group of more than 5 employees:*
  No medical questionnaire will, in principle, be required for the core plan as set out in Section A of this Policy.

  For the optional benefits as set out in Section B of this Policy, however, the completion of a medical questionnaire might be required, and the Medical Consultant can at his discretion define partial or total exclusion of cover or propose additional premium to waive exclusions.

- *In all other cases:*
  A medical questionnaire has to be completed by each Insured Person and has to be submitted to the Medical Consultant of the Company. The Medical Consultant can at his discretion define partial or total exclusion of cover or propose an additional premium to waive exclusions.

The Effective Date for a newborn child of an Insured Person is the moment of birth, provided notification was given to

the Company within 4 weeks of the date of birth and a parent was insured for at least 10 continuous months immediately prior to the date of birth.
In case of compulsory affiliation by the employer of a group of more than 5 employees:
If an Insured Person was covered by a Preceding Policy and that Insured Person was afflicted with an Illness or Injury at the time of the Effective Date for which benefits would have been available under the Preceding Policy had it remained in force, the Insured Person will be covered for the existing Illness or Injury under this policy**.** The cover will not exceed the limits of the provisions of the Preceding Policy or the provisions of this Policy, whichever are the lesser.

2.4 Area of Cover

The policy covers the Insured Person within his Area of Cover as mentioned in the policy schedule.

Cover outside the Insured Person's Area of Cover is limited to emergencies in case of leisure or business travel, taking place during the Benefit Period and lasting no longer than 90 consecutive days, and excluding any travel if the purpose of the trip is to obtain medical treatment or medical advice or in case the Insured Person is traveling against the advice of a Physician.

2.5 Termination of Benefits

The benefits for the Insured Person under this Policy terminate on the earliest of the following moments:

- At midnight on the last day of the Policy Period
- The moment the concerned benefit of this policy have been exhausted
- On the next annual policy renewal date following the 75th birthday of the Insured Person
- The moment the Expatriated Employee and his Dependants, become or could have become covered by the National Health Service of their Home Country in case of the ending of the expatriate assignment of the Expatriated Employee, and at the latest 6 months after the end of the expatriate assignment
- The moment the Insured Person becomes or could have become covered by the National Health Service of his Home Country in case of the relocation of the Insured Person to his Home Country, and at the latest 6 months after the relocation to his Home Country.

2.6 Payment of Premiums

The *Policyholder* is liable to pay the *Premium* stated in the *Schedule* by the *Premium Due Date* as stated in the *Schedule,* unless otherwise agreed in writing by the *Policyholder* and the *Insurer*. Should the *Policyholder* fail to settle the insurance *Premium* on or before the due date, the *Insurer* shall be entitled to request payment in writing, by granting a 30-day grace period and also warning the *Policyholder* to the consequences of non-payment. The insurance contract shall terminate retroactively with effect of the original due date if the grace period expires without the *Policyholder* settling the insurance *Premium*, unless the *Insurer* takes legal action as to the enforcement of its claim before court without delay. In such case the *Policyholder* shall be entitled to request the *Insurer* to reactivate the insurance coverage within one hundred and twenty days from the date of termination of the insurance contract. The *Insurer* may reactivate the insurance coverage under the terms and conditions of the terminated contract on condition that the formerly due insurance premium is paid. Should the *Policyholder* fail to pay the due insurance *Premium* (premium installment) and the *Insurer* fail to send its request of payment as stated above, the contract shall terminate at the end of the insurance period.

2.7 Change of Risk

The Policyholder and Insured Person shall inform the Company immediately of any significant change in circumstances or conditions that may increase the risk. This includes but is not limited to changes in business activities, change of Home Country, or change of Host Country.

If such change is not a change in the health state of the Insured Person and the change involves an increased risk, the Company has the right during 15 days to cancel the insurance cover with a 30-day notice or to increase the premium and the conditions of insurance, and this retroactively as from the moment of the aggravation of the risk.

The Policyholder shall have the right to refuse the amended premium and conditions of insurance by cancelling the policy within 60 days of the date on which the Policyholder was informed of the amendment. In this case the policy will terminate on the 60th day.

2.8 Change of Premium Rates and/or Conditions

The premiums of the Core Plan and the Dental & Vision Care Plan may be adjusted at each annual renewal date, based on the attained age of each Insured Person on the renewal date and based on the increase in medical expenses.
The Company shall have the right to change the premium and/or conditions of certain insurance covers on a class basis for all similar covers.

The Company shall inform the Policyholder in writing at least 60 days before the next annual Policy Period. The Policyholder is deemed to have accepted this unless the Policyholder cancels the agreement as from the date on which the change takes effect with 30 days notice period. In the latter case, the insurance shall end at midnight of the last day of the previous annual Policy Period.

The Policyholder shall not have the right to cancel the policy if the change involves a reduction of the premium or an extension of the cover without premium increase.

2.9 Cancellation in the Event of War

The Company and the Policyholder may cancel any cover for War if such risk is manifested or if this is about to happen, subject to 7 days' notice.

2.10 Sanctions Exclusion

The Insurer shall not assume any payment obligation with respect to any damage otherwise covered by the Insurance Contract and its extensions if the Insured or the beneficiary is the national or a government agency of a country against which the laws and/or other regulations determining the present insurance coverage and/or the Insurer, its parent company or the operation of the company that has an influence ensuring qualified majority in the Insurer, have introduced an embargo or another economic sanction that prohibits the Insurer from entering into insurance transactions or providing other economic benefits to the Insured or any other beneficiary.
Furthermore, no payments shall be made to the beneficiary/beneficiaries to whom/which no economic benefits shall be provided in accordance with the laws and/or other regulations pertaining to the Insurer, its parent company or the company having influence that ensures qualified majority in the Insurer.

2.11 Notification of Claim

The Policyholder, Insured Person or Beneficiary shall respect the procedures mentioned under the title "Claims Procedure" of the concerned benefit, and shall notify the Company within 8 days following the occurrence of an event covered by this insurance policy if not regulated otherwise in the specific covers. If they do not report the occurrence of the insured event within the time limit determined in the contract, and as a consequence of the delay, it becomes impossible to ascertain the relevant circumstances, the Insurer's obligation shall not arise.

In case of a claim the following documents shall be provided to the Company

General documents:

- Completed and duly signed claim request form (policy number, address, data needed for the transfer of payments)
- Employer's certificate if the employee is covered by a company group insurance
- Medical documentation (ambulant sheet containing the diagnose of the disease/sickness, final report of the hospital, treatment sheet, histological findings, contact details of the doctor, medical case history, medical documentation of the PCP about any disease/sickness or accident preceding the travel, certification issued by the doctor about the expected recovery date, sick allowance documents, medical documentation stating the extent of the disability, decision of National Medical Expert Institute, medical expert opinion)

- Invoices (invoices about the hospitalization; invoices about the medicaments and the transportation of the patients that are required for the assessment of the insurance benefits, payment certificate, invoice about the issuance of the official documents; invoice about the reparation of baggage, invoice of accommodation, flight booking, taxi, phone, or fuel or any other invoice which proofs the claim)
- Policy report (if available), or other official report/report of any other authority (if available)
- Documents certifying the travel (booking, visa, boarding pass, baggage ticket, copy of the passport stamp, In case of travelling with car, declaration about the exact date of departure)
- Copy of the bank statement, any other certificate of the money exchange
- Description of the accident, or event including the names of possible eyewitnesses
- Medical case history, medical documentation of the PCP about any disease/sickness or accident preceding the travel

Documents requested in relation to the coverages beside the general documents:

Accidental death:
- Death certificate, autopsy report, medical certificate proving the reason of the death
- Certificate of inheritance, Grant of probate; decision or record of an official procedure (if any)

Permanent Disability (total or partial) due to an accident:
- Medical documentation stating the extent of the disability, decision of National Medical Expert Institute, medical expert opinion;
- Invoices about retraining expenses, certification of the retraining institution on the training and the participation

Recovery cash:
- Sick allowance documents
- Certification issued by the doctor about the expected recovery date

Temporary total disability due to sickness or accident:
- Sick allowance documents
- Certification issued by the doctor about the expected recovery date
- In case the limit is based on the amount of the daily wage, the amount of the wage that was stated on the claim request form shall be officially certified by the employer

Accidental death in a plane crash:
- Certification of the airline company that the Insured was on the passenger list and travelled on the plane
- Certification of the Ministry of Foreign Affairs about the plane crash

Personal belongings, baggage, baggage delay:
- Detailed description about the lost or damage of the baggage
- 'Passenger Irregularity Report', certification or statement of the airline/transportation company about the damage, lost or injury
- Certification of the airline/transportation company about the indemnification paid to the passenger
- Detailed list of the lost and damaged items, containing the purchase price and the date of purchase, Invoices certifying the purchase (if available)
- In case of any damage: invoice about the reparation, or statement that damaged item cannot be repaired
- check in receipt, baggage ticket, certification of costs and expenses of the reasonable required shopping abroad, certification of receipt of the baggage containing the date, time and name of the passenger

Money: documents certifying the financial loss, certification of the possession

Cash: certification of the cash withdrawal and the money exchange

Flight delay or cancellation, air-route change:

- Certification of the airline/transportation company about the delay or cancellation, certification of the original flight with the original ticket or reservation and the new departure with the new boarding pass; flight number, destination country and city where the flight was delayed or cancelled

Cancellation of the trip:

- Document certifying the reason of cancellation (such as medical documentation, etc.)
- Original of the ticket reservation, invoice about the ticket
- Certification of payments of the items that can be reimbursed from other sources (for example reimbursement of the airline company, refund of the advance payments of booked services, etc.)

Home transportation of corps and relics:

- Birth certificate, marriage certificate, death certificate, medical certificate proving the reasons of the death, autopsy report

Legal costs:

- Certification of the power of attorney; certification of the arrest and its circumstances

Bail bond: Certification of the amount of the bail

Personal liability insurance: Power of Attorney

Liability insurance:

- Power of Attorney; description of the extent of the damage in case of material damage
- expert opinion of the loss adjustor; opinion of the service center that the damaged good/thing cannot be repaired

2.12 Proof and Payment of Claims

The Policyholder, Insured Person or Beneficiary shall provide at their own expense the above listed documents to substantiate the claim. They shall cooperate in medical or other examinations or enquiries related to the claim if the Company deems this necessary. The Company will pay the benefit following the receipt of all documents required for claim settlement within 15 days from the receipt of the last document, if not regulated otherwise in the specific covers.

2.13 Reasonable Care

The Policyholder, Insured Persons and Beneficiaries must take all reasonable steps to avoid and/or minimize expenses, loss or damage and must also make every effort to recover any property covered by this policy which has been lost or stolen.

2.14 Obligations and Stipulations

The Policyholder and the Insured Persons shall comply with the obligations and stipulations set out in the policy. If the Policyholder or the Insured Person fails to do so, the Company may deduct any consequential loss it has incurred.

2.15 Obligation to give responses

The Policy holder and Insured person shall provide information by giving truthful responses to the Insurer. They must provide information about the legal basis and actual amount, and circumstances of the reported insured event to be verified by the Insurer. They must provide the necessary documents. If they will not provide necessary information or documents and because of it the occurrence of the insured event becomes impossible to ascertain, the Insurer shall not pay the benefit.

2.16 Derogation from the provision of the Civil Code

Limitation period of any claims arising out of the Insurance contract shall lapse after two (2) years from the due date which is a derogation from section 6:22§ of the Act V of 2013 on the Civil Code. Any previous contractual / business practices, habits of the parties, or the common contractual practice of the insurance business shall not become part of the contract which is a derogation from section 6:63 § of the Act V of 2013 on the Civil Code.

2.17 Fraud

The Policyholder, Insured Person or Beneficiary will lose any benefit in case of fraud, deliberate dishonesty or deliberate hiding of information, and they must pay back any benefit that the Company has already paid, and shall compensate the Company for the loss or damage incurred because of this situation. If this happens, the Company will not refund any premium and has the right to immediately cancel the policy.

2.18 Interest on Payments

The Company shall not pay interest on payments to be made.

2.19 Other Insurance and Subrogation

If the liability, loss or damage that is covered under this policy is also covered by a National Health Service or under any other insurance policy, whether or not of an earlier date, or would have been covered under these had this insurance not been taken out, this insurance shall only provide cover in excess of what would have been covered by the National Health Service and such other insurance policy. The amounts paid under this insurance shall not exceed, when combined with the amounts paid by the National Health Service and under such other insurance policy, the maximum limits as mention on the policy schedule.

The Policyholder, Insured Person or Beneficiary shall inform the Company of such cover and provide the Company, at request, with a copy of the policy including the benefit schedules.

In the event of Injury, loss or damage involving the actions or negligence of a third party, the Policyholder, Insured Person or Beneficiary shall use their best endeavors to claim from such third party for the full amount of the loss. The Policyholder, Insured Person and Beneficiary shall not negotiate, settle, compromise, release, or otherwise discharge any claim against such a party without the Company's express written consent. The Company has full rights of subrogation and may take proceedings in the Insured Person's name, but at the Company's expense, to recover for the Company's benefit the amount of any payment made under the policy including but not limited to the cost of such proceedings.

2.20 Transfer

The policy cannot be transferred unless otherwise agreed upon in writing with the Company.

2.21 Term of Limitation

A claim against the Company to make a payment shall lapse by the passage of 2 years after the start of the day following the day on which the person entitled to payment became aware of the payment being due and payable.

The period of limitation is interrupted by a written notification whereby a claim to payment is made. A new period of limitation shall commence with the start of the day following the day on which the Company either acknowledges the claim or announces by registered letter that it has rejected the claim, unambiguously stating that in the event of rejection the claim shall lapse by the passage of six months.

2.22 Address

The Company can give valid notice to the Policyholder at his last address known by the Company.

2.23 Information on professional secrecy and personal data management

Insurance secret shall mean all data - other than classified information - in the possession of insurance companies, reinsurance companies and insurance intermediaries that pertain to the personal circumstances and financial situations (or business affairs) of their clients (including claimants), and the contracts of clients with insurance companies and reinsurance companies.

Insurance and reinsurance companies are entitled to process the insurance secrets of clients only to the extent that they relate to the relevant insurance contract, with its creation and registration, and to the service. Processing of such data shall take place only to the extent necessary for the conclusion, amendment and maintenance of the insurance contract and for the evaluation of claims arising from the contract or for any other purpose specified in the Insurance Act.

Insurance and reinsurance companies shall obtain the data subject's prior consent for processing data for purposes other than what is contained in Subsection (1) Section 135 of Act LXXXVIII of 2014 (Insurance Act). The client shall not suffer any disadvantage if the consent is not granted, nor shall be given any advantage if it is granted.

Unless otherwise provided for by law, the owners, directors and employees of insurance and reinsurance companies, and all other persons having access to insurance secrets in any way during their activities in insurance-related matters shall be subject to the obligation of professional secrecy without any time limitation.

According to the Act on the Processing and Protection of Personal Data in the Field of Medicine (hereinafter referred to as "PDFM"), insurance companies shall be authorized to process any data pertaining to the medical condition of clients only for those 3 reasons set out in Subsection (1) of Section 135 of the Insurance Act, in accordance with the provisions of PDFM and only in possession of the express written consent of the data subject.

Insurance secrets may only be disclosed to third parties:

a) under the express prior written consent of the insurance or reinsurance company's client to whom they pertain, and this consent shall precisely specify the insurance secrets that may be disclosed;
b) if there is no obligation of professional secrecy under the Insurance Act.
c) if the certification body, including its subcontractor, hired by an insurance or reinsurance company, received such confidential information in carrying out the certification process.

The requirement of confidentiality concerning insurance secrets shall not apply to:

a) the Authority in exercising its designated functions;
b) the investigating authority and the public prosecutor's office after ordering the investigation;
c) the court of law in connection with criminal cases, civil actions or non-contentious proceedings, and administrative actions, including the experts appointed by the court, and the independent court bailiff, the administrator acting in bankruptcy proceedings, the temporary administrator, extraordinary administrator, liquidator acting in liquidation proceedings in connection with a case of judicial enforcement, the principal creditor in debt consolidation procedures of natural persons, the Családi Csődvédelmi Szolgálat (Family Bankruptcy Protection Service), the family administrator, the court;
d) notaries public, including the experts they have appointed, in connection with probate cases;
e) the tax authority in the cases referred to in Subsection (2);
f) the national security service when acting in an official capacity,
g) the Gazdasági Versenyhivatal (Hungarian Competition Authority) acting in an official capacity;
h) guardians acting in an official capacity,
i) the government body in charge of the healthcare system in the case defined in Subsection (2) of Section 108 of Act CLIV of 1997 on Health Care;
j) bodies authorized to use secret service means and to conduct covert investigations if the conditions prescribed in specific other act are provided for;
k) the reinsurer and in case of co-insurance, the insurers underwriting the risk,

l) with respect to data transmitted as governed by law, the bureau of insurance policy records maintaining the central policy records, the claims registry body operating the central claims history register, furthermore, the national transport authority and the Central Office for Administrative and Electronic Public Services in respect of any official affairs related to road traffic management tasks concerning motor vehicles not covered by the register [while upon receipt of a written request from a body or person referred to in Paragraphs a)-j), n) and s) of Subsection (1) of Section 138 of the Insurance Act indicating the name of the client or the description of the insurance contract, the type of data requested and the purpose of and the grounds for requesting data, with the exception that the bodies or persons referred to in Paragraphs p)-s) are required to indicate only the type of data requested and the purpose and grounds for requesting it. An indication of the statutory provision granting authorization for requesting data shall be treated as verification of the purpose and legal grounds.

m) the receiving insurance company with respect to insurance contracts conveyed under a portfolio transfer arrangement, as provided for by the relevant agreement;

n) with respect to the information required for settlement and for the enforcement of compensation claims, and also for the conveyance of these among one another, the body operating the Compensation Fund and/or the Claims Guarantee Fund, the National Bureau, the correspondent, the Information Centre, the Claims Organization, claims representatives and claims adjustment representatives, or the responsible party if wishing to access - in exercising the right of self-determination - the particulars of the other vehicle that was involved in the accident from the accident report for the purpose of settlement;

o) the outsourcing service provider with respect to data supplied under outsourcing contracts; the tax auditor in respect to data supplied under tax audit agreements [while, upon receipt of a written request from a body or person referred to in Paragraphs a)-j), n) and s) of Subsection (1) of Section 138 of the Insurance Act indicating the name of the client or the description of the insurance contract, the type of data requested and the purpose of and the grounds for requesting data, with the exception that the bodies or persons referred to in Paragraphs p)-s) are required to indicate only the type of data requested and the purpose and grounds for requesting it. An indication of the statutory provision granting authorization for requesting data shall be treated as verification of the purpose and legal grounds.]

p) third-country insurance companies and insurance intermediaries in respect of their branches, if they are able to satisfy the requirements prescribed by Hungarian law in connection with the management of each datum and the country in which the third-country insurance company is established has regulations on data protection that conform to the requirements prescribed by Hungarian law;

q) the commissioner of fundamental rights when acting in an official capacity;

r) the Nemzeti Adatvédelmi és Információszabadság Hatóság (the National Authority for data Protection and Freedom of Information) when acting in an official capacity;

s) the insurance company in respect of the bonus-malus system and the bonus-malus rating, and the claims record and the bonus-malus rating in the cases specified in the decree on the detailed rules for the verification of casualties, upon receipt of a written request from a body or person referred to in Paragraphs a)-j), n) and s) of Section 138 of the Insurance Act indicating the name of the client or the description of the insurance contract, the type of data requested and the purpose of and the grounds for requesting data, with the exception that the bodies or persons referred to in Paragraphs p)-s) are required to indicate only the type of data requested and the purpose and grounds for requesting it. An indication of the statutory provision granting authorization for requesting data shall be treated as verification of the purpose and legal grounds.

t) the agricultural damage survey body, the agricultural administration body, the agricultural damage compensation body, and the institution delegated to conduct economic assessments under the supervision of the ministry directed by the minister in charge of the agricultural sector in respect of insured persons claiming any aid for the payment of agricultural insurance premiums;

u) the authority maintaining a register of liquidator companies;

upon receipt of a written request from a body or person referred to in Paragraphs a)-j), n), s), t) and u) indicating the name of the client or the description of the insurance contract, the type of data requested and the purpose of and the grounds for requesting data, with the exception that the bodies or persons referred to in Paragraphs p)-s) are required to indicate only the type of data requested and the purpose and grounds for requesting it. An indication of the statutory

provision granting authorization for requesting data shall be treated as verification of the purpose and legal grounds.

Pursuant to Paragraph e) of Subsection (1) of Section 138 of the Insurance Act, there shall be no confidentiality obligation concerning insurance secrets in connection with tax matters where the insurance company is required by law to disclose specific information to the tax authority upon request and/or to disclose data concerning any payment made under an insurance contract that is subject to tax liability.

The requirement of confidentiality concerning insurance secrets shall not apply to financial institutions stipulated by the Act on Credit Institutions and Financial Enterprises with regard to an insurance contract related to any receivable arising out of financial service, provided that the financial institution submits its request in writing to the insurance company which contains the name of the client or the insurance contract, all types of data requested, the purpose of the information request and its title.

The disclosure made by the insurance company to the tax authority in compliance with the obligation prescribed in Sections 43/B-43/C of Act XXXVII of 2013 on International Administrative Cooperation in Matters of Taxation and Other Compulsory Payments (hereinafter referred to as "IACA") in accordance with Act XIX of 2014 on the Promulgation of the Agreement between the Government of Hungary and the Government of the United States of America to Improve International Tax Compliance and to Implement FATCA, and on the Amendment of Certain Related Acts (hereinafter referred to as "FATCA Act") shall not be construed as violation of insurance secrets.

Insurance and reinsurance companies shall be authorized to disclose the personal data of clients in the cases and to the agencies indicated in Subsections (1) and (6) of Section 138 and in Sections 137, and 140 of the Insurance Act.

The obligation of insurance secrecy shall apply to the employees of the agencies specified in Subsection (1) of Section 138 of the Insurance Act beyond the purview of any legal process.

Insurance and reinsurance companies shall be required to supply information forthwith where so requested in writing by the national security service, the public prosecutor or the investigating authorities under the prosecutor's consent if there is any suspicion that an insurance transaction is associated with:

a) misuse of narcotic drugs, illegal possession of new psychoactive substances, acts of terrorism, criminal misuse of explosives or blasting agents, criminal misuse of firearms and ammunition, money laundering, or any felony offense committed in criminal conspiracy or within the framework of a criminal organization under Act IV of 1978 in force until 30 June 2013,
b) unlawful drug trafficking, possession of narcotic drugs, inciting substance abuse, aiding in the manufacture or production of narcotic drugs, illegal possession of new psychoactive substances, acts of terrorism, failure to report a terrorist act, terrorist financing, criminal misuse of explosives or blasting agents, criminal misuse of firearms and ammunition, money laundering, or any felony offense committed in criminal conspiracy or within the framework of a criminal organization under the Criminal Code.

The obligation of confidentiality concerning insurance secrets shall not apply where an insurance or reinsurance company complies with the obligation of notification prescribed in the Act on the Implementation of Restrictive Measures Imposed by the European Union Relating to Liquid Assets and Other Financial Interests.

The disclosure of the group examination report to the dominating member of the financial group during the supervisory oversight proceedings in the case of group supervision shall not constitute a breach of confidentiality concerning insurance secrets and trade secrets.

The disclosure of information provided in compliance with Section 164/B shall not be construed a breach of insurance secrets.

The obligation to keep insurance secrets shall not apply when:

a) a Hungarian law enforcement agency makes a written request for information - that is considered insurance secret - in order to fulfil the written requests made by a foreign law enforcement agency pursuant to an international agreement;
b) the national financial intelligence unit makes a written request for information - that is considered insurance secret - acting within its powers conferred under the Act on the Prevention and Combating of Money Laundering and Terrorist Financing or in order to fulfil the written requests made by a foreign financial intelligence unit.

It shall not constitute a violation of insurance secrecy where an insurance or reinsurance company supplies information to a third-country insurance or reinsurance company or a third-country data processing agency:
a) if the client to whom such information pertains (hereinafter referred to as "data subject") has given his prior written consent, or
b) if - in the absence of the data subject's consent - the data is disclosed within the scope, for the purposes and on the legal grounds specified by law, and the level of protection available in the third-country satisfies either of the requirements prescribed in Subsection (2) of Section 8 of Act CXII of 2011 on the Right of Informational Self-Determination and on Freedom of Information (hereinafter referred to as "Info Act").

The provisions governing data disclosure within the domestic territory shall be observed when sending data that is treated as an insurance secret to another Member State.

The following shall not be construed a breach of insurance secrecy:
a) the disclosure of data compilations from which the clients' personal or business data cannot be identified;
b) in respect of branches, transfer of data for the purpose of supervisory activities to the supervisory authority of the country where the registered address (main office) of the foreign-registered company is located, if such transfer is in compliance with the agreement between the Hungarian and the foreign supervisory authorities;
c) disclosure of information, other than personal data, to the minister for legislative purposes and in connection with the completion of impact assessments;
d) the disclosure of data in order to comply with the provisions contained in the Act on the Supplementary Supervision of Financial Conglomerates.

(2) Insurance and reinsurance companies may not refuse to disclose the data specified in Subsection (1) of Section 141 of the Insurance Act on the grounds of protection of insurance secrets.
The personal data indicated in the data transfer records and the data covered by Section 136 of the Insurance Act, or the data treated as special data under the Info Act shall be deleted, respectively, after five years and twenty years following the date of disclosure.

The insurance or reinsurance company shall not be authorized to notify the data subject when data is disclosed pursuant to Paragraphs b), f) and j) of Subsection (1) of Section 138 or Subsection (6) of Section 138 of the Insurance Act.

Insurance and reinsurance companies shall be entitled to process personal data during the life of the insurance or reinsurance contract or other contractual relation, and as long as any claim can be asserted in connection with the insurance, reinsurance or contractual relation.

Insurance and reinsurance companies shall be entitled to process personal data relating to any unconcluded insurance or reinsurance contract as long as any claim can be asserted in connection with the failure of the contract.

Insurance and reinsurance companies shall be required to delete all personal data relating to their current or former clients or to any frustrated contract in connection with which the data in question is no longer required, or the data subject has not given consent, or if it is lacking the legal grounds for processing such data.

(3) Within the meaning of the Insurance Act, the processing of data related to deceased persons shall be governed by

the statutory provision on the processing of personal data. The rights of a deceased person in terms of data processing may be exercised by the heir or by the person named as the beneficiary in the insurance contract.

Trade secrets of insurance companies and reinsurance companies

Insurance and reinsurance companies and their owners, any proposed acquirer of a share in an insurance or reinsurance company, as well as the senior executives, non-management officers and employees, agents of insurance or reinsurance companies shall keep any trade secrets made known to them in connection with the operation of the insurance or reinsurance company confidential without any time limitation.

The obligation of confidentiality prescribed in Section 144 of the Insurance Act shall not apply to the following in exercising their designated functions:

a) the Authority;
b) the national security service;
c) the Állami Számvevőszék (State Audit Office);
d) the Gazdasági Versenyhivatal (Hungarian Competition Authority);
e) the internal oversight agency tasked by the Government, which controls the legality and propriety of the use of central budget funds;
f) property administrators;
g) the Információs Központ (Information Center);
h) the agricultural damage survey body, the agricultural damage compensation body, the agricultural administration body, and the institution delegated to conduct economic assessments under the supervision of the ministry directed by the minister in charge of the agricultural sector in respect of insured persons claiming any aid for the payment of agricultural insurance premiums.

The disclosure made by an insurance company to the tax authority in compliance with the obligation prescribed in Sections 43/B-43/C of the IACA in accordance with the FATCA Act shall not be construed as violation of trade secrets.

(3) The disclosure of information by the Authority to the European Insurance and Occupational Pensions Authority (hereinafter referred to as “EIOPA”) as provided for in Regulation (EU) No. 1094/2010 of the European Parliament and of the Council of 24 November 2010 establishing a European Supervisory Authority (European Insurance and Occupational Pensions Authority), amending Decision No. 716/2009/EC and repealing Commission Decision 2009/79/EC (hereinafter referred to as “Regulation 1094/2010/EU”) shall not be construed as violation of trade secrets.

The obligation of confidentiality prescribed in Section 144 of the Insurance Act shall not apply to:

a) the investigating authority and the public prosecutor’s office after ordering the investigation;
b) the court of law in connection with criminal cases, civil actions and non-contentious proceedings, and the judicial review of administrative decisions, including the experts appointed by the court, and the independent court bailiff in connection with a case of judicial enforcement, and to the court in local government debt consolidation procedures.

(5) The disclosure of information by the Authority to the minister in charge of the money, capital and insurance markets on insurance and reinsurance companies, enabling individual identification, for legislative purposes and in connection with the completion of impact assessments shall not be construed a breach of trade secrecy.

(6) The disclosure of information by the Information Centre in an official capacity shall not be construed a breach of trade secrecy.

The person acquiring any trade secrets shall keep them confidential without any time limitation.

By virtue of the obligation of secrecy, no facts, information, know-how or data within the sphere of trade secrets may be disclosed to third parties beyond the scope defined in the Insurance Act without the consent of the insurance or

reinsurance company, or the client concerned, or used beyond the scope of official responsibilities.

The person acquiring any trade secrets may not use such for his own benefit or for the benefit of a third person, whether directly or indirectly, or to cause any disadvantage to the insurance or reinsurance company affected, or its clients.

In the event of dissolution of an insurance or reinsurance company without succession, the business documents managed by the insurance or reinsurance company and the documents containing trade secrets may be used for archival research conducted after sixty years of their origin.

Any information that is declared by the Info Act to be information of public interest or public information, and as such is rendered subject to disclosure may not be withheld on the grounds of being treated as a trade secret or insurance secret.

Other matters relating to insurance secrets and trade secrets shall be governed by the relevant provisions of the Hungarian Civil Code.

Data management relating to data exchange between Insurance Companies

In discharging the obligations delegated by law, or fulfilling their contractual commitments, in order to provide services in compliance with the relevant legislation or as contracted, and to prevent insurance fraud, the Insurance Company shall - in order to protect the interest of risk groups of insureds - have the right to make a request to another insurance company from 1 January, 2015 with respect to data processed by this insurance company and referred to in Subsections (3)-(5) of Section 149 of the Insurance Act in accordance with Subsection (1) of Section 135 thereof, taking into account the unique characteristics of insurance products affected. The request shall contain the information necessary for the identification of the person, property or right defined therein, it shall specify the type of data requested and the purpose of the request. Making a request and complying with one shall not be construed a breach of insurance secrecy.

In this context the Insurance Company may request the following data from other insurance companies:

Data listed in Paragraphs a) to e) of Subsection 3 of Section 149 of the Insurance Act relating to the conclusion and performance of the insurance contracts pertaining to the insurance class stipulated in points 1 and 2 of Section A of Annex 1 of the Insurance Act;

Data listed in Paragraphs a) to e) of Subsection 4 of Section 149 of the Insurance Act relating to the conclusion and performance of the insurance contracts pertaining to the insurance class stipulated in points 5, 6, 7, 8, 9, 16, 17 and 18 of Section A of Annex 1 of the Insurance Act; and

Data listed in Paragraphs a) to c) of Subsection 5 of Section 149 of the Insurance Act relating to the conclusion and performance of the insurance contracts in case of the prior consent of the claimant pertaining to the insurance class stipulated in points 11, 12, and 13 of Section A of Annex 1 of the Insurance Act.

The requested insurance company shall make available to the requesting Insurance Company the data requested in due compliance with the law, inside the time limit specified in the request, or failing this, within fifteen (15) days from the date of receipt of the request.

The requesting Insurance Company shall be allowed to process data obtained through the request for a period of ninety (90) days from the date of receipt. If the data obtained by the requesting Insurance Company through the request is necessary for the enforcement of that Insurance Company's lawful interest, the time limit specified above for data processing shall be extended until the enforceable conclusion of the procedure opened for the enforcement of such claim.

If the data obtained by the requesting Insurance Company through the request for the enforcement of the insurance company's lawful interest, and the procedure for the enforcement of such claim is not opened inside a period of one

(1) year after the data is received, such data may be processed for a period of one (1) year from the date of receipt. The requesting Insurance Company shall inform the client affected by the request concerning this request and also if the request is satisfied, on the data to which it pertains, at least once during the period of insurance cover.

If the client asks for information regarding his data in accordance with the Info Act and the requesting insurance company no longer has the data to which the request pertains having regard to Subsections 8-10 of Section 149 of the Insurance Act, the client shall be informed thereof.

The requesting Insurance Company shall not be allowed to connect the data obtained through the request relating to an interest insured, with data it has obtained or processed, for purposes other than the above. The requested insurance company shall be responsible for the correctness and relevance of the data indicated in the request."

Information on handling of personal data
Data controller: Colonnade Insurance S.A.
Contact details of the data protection officer:
email: dpo@colonnade.hu, Phone number: (06-1) 460-1400, Mailing address: 1426 Budapest, Pf.:153

Categories of data:

personal data: any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, place and time of birth, an identification number, address, an online identifier

special data: medical data

Purposes of the processing
The Insurance Company has the right to process confidential insurance information of clients in relation to the insurance contract, its establishment, its registry and the service provided. Processing of such data shall take place only to the extent necessary for the conclusion, amendment and maintenance of the insurance contract and for the evaluation of claims arising from the contract or for any other purpose specified in the Act LXXXVIII of 2014.

Data processing purposes include ensuring to comply with restrictive economic measures and anti-money laundering and terrorist financing obligations imposed by the United Nations, the European Union, or other relevant organisations. The Insurance Company shall transfer personal data (name) to its data processors residing in the United States according to the adequacy decision by the Commission and according to the Privacy Shield Framework.

Contracts established online via colonnade.hu are subject to the Act XXV of 2005 and to the Act CVIII of 2001, thus the purpose of data processing includes proving the compliance with the obligation to provide consumer information; proving the establishment of the contract; establishing, modifying and monitoring the fulfilment of a service provisioning contract in relation to the information society; billing for the services provided under the contract; and enforcing the related claims.
The Insurance Company's data processing is either based on the establishment of the contract, or on the voluntary consent made by the client during the submission of claims, service requests, information requests regarding the contract. If transferring the medical data of a client outside the European Union is necessary in order to protect the vital interests of the data subject regarding a travel insurance contract, the Insurance Company shall inform the data subject of the transfer.

The Insurance Company processes personal data obtained during complaint handling to comply with the Act LXXXVIII of 2014, Section 159, and keeps a record of its clients' complaints, and of actions taken to remedy these complaints. The Insurance Company's data processing is based on this provision of the Act LXXXVIII of 2014.

According to the above cited paragraph of the Act LXXVIII of 2014, if the complaints are handled by telephone, the Insurance Company shall record the conversation between the Insurance Company and the client.

Period of data processing

Insurance company shall be entitled to process personal data - medical data – concerning insurance secrets during the life of the insurance contract, and other contractual relation, as long as any claim can be asserted in connection with the contractual relation. Insurance company shall be entitled to process personal data relating to any unconcluded insurance contract as long as any claim can be asserted in connection with the failure of the contract. According to the Act C of 2000 on accounting Section 169, the accounting records in relation to the establishment of the insurance contract, its registry and the insurance services are retained by the Insurance Company for eight years.

The Insurance Company handles the information received from other insurance companies during data exchanges with the conditions and within the time periods set out in the "Data protection in relation to data exchanges between insurance companies" section.

During complaint handling, the sound recordings are retained by the Insurance Company for five years. The Insurance Company retains the complaint and the reply provided for a period of five years, and shall make them available at the request of the authorities.

Legal basis for data processing

The legal bases of data processing in relation to handling insurance contracts, registering insurance contracts, and telephone customer services are the followings: the consent of the data subjects; the Act LXXXVIII of 2014 Section 135; the Act C of 2000 Section 169. In case of online contracting or contracting via telephone, the legal bases of data processing are the Act XXV of 2005 Section 2 and the Act CVIII of 2001, Section 13/A. Data in relation to a client's health condition shall only be processed with the expressed written consent of the data subject, in accordance with the Act XLVII of 1997.

The legal basis for data processing in relation to customer complaints is the Act LXXXVIII of 2014 Section 159.

In case of restrictive economic measures (embargo) imposed by the United Nations, the European Union, or other relevant organisations, the legal basis for data processing is the legitimate interest of the Insurance Company and the compliance with its legal obligation.

The data subject rights and exercising these rights

1. The data subjects' rights include the followings:

a) The client has the right to request access from the controller regarding his/her personal data;
b) The client has the right to request the rectification of inaccurate personal data or to have incomplete personal data completed;
c) The client has the right to request from the controller the erasure of personal data or the restriction of processing his/her data;
d) The client has the right to object to the processing of personal data;
e) The client has the right to lodge a complaint with a supervisory authority (NAIH);
f) The client has the right to data portability; and
g) The client has the right to prohibit the usage of personal data for direct marketing purposes.

a) Upon the request of the client, the Insurance Company shall provide information in writing on any and all Personal Data of him/her within 15 days about the followings:

- the source and categories of personal data;
- the purposes and legal bases of data processing;

- where possible, the envisaged period for which the personal data will be stored, or, if not possible, the criteria used to determine that period;
- the recipients or categories of recipient to whom the personal data have been or will be disclosed;
- the name and address of the Data controller, and the issues relating to processing.

The Insurance Company shall provide these information free of charge, if the client (natural person) has not submited a request on the same data within the scope in the same year. In other cases, a reasonable fee can be charged taking into account the administrative costs of providing the requested information.

In addition to this, at the client's request the copy of the personal data shall be made available.

b) If a data concerned is inaccurate, the client shall have the right to request and have it promptly updated.

c) The Insurance Company erase the personal data without undue delay if one of the following grounds applies:
- the personal data are no longer necessary in relation to the purposes for which they were collected; or
- the data subject withdraws consent, and there is no other legal ground for the processing;

unless, the data is for the establishment, exercise or defence of legal claims, or for compliance with a legal obligation. The Insurance Company erase the personal data without undue delay for compliance with a legal obligation to which the controller is subject, or if the personal data have been collected in relation to the offer of information society services referred to the Act CVIII of 2001 section 8 paragraph 1.

The client shall have the right to obtain restriction of processing from the controller where one of the following applies:
- the accuracy of the personal data is contested by the client, in that case restriction applies for a period enabling Controller to verify the accuracy of the personal data concerned;
- the processing is unlawful, and the data subject opposes the erasure of the personal data and requests the restriction of their use instead;
- the controller no longer needs the personal data for the purposes of the processing, but they are required by the data subject for the establishment, exercise or defence of legal claims;
- the data subject has objected to processing pursuant to Article 21(1) pending the verification whether the legitimate grounds of the controller override those of the data subject;
- the data subject has objected to processing, in that case restriction applies for the period during which it is verified whether the legitimate grounds of controller may override those of the client.

Where processing has been restricted, such personal data shall be processed with the data subject's consent or for the establishment, exercise or defence of legal claims or for the protection of the rights of another natural or legal person or for reasons of important public interest of the Union or of a Member State. A data subject who has obtained restriction of processing pursuant shall be informed by the controller before the restriction of processing is lifted.
d) If the processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party, the data subject shall have the right to object, on grounds relating to his or her particular situation, at any time to processing of personal data concerning him or her, including profiling based on those provisions.

The controller shall no longer process the personal data unless the controller demonstrates compelling legitimate grounds for the processing which override the interests, rights and freedoms of the data subject or for the establishment, exercise or defence of legal claims. The Insurance Company examine the claim within 15 days and if it finds it a reasoned objection, the Company shall inform the Client about the decision in writing.

Should any complaint arise regarding the processing of the personal data, we undertake the obligation to inform our client on the right to object or submit a complaint orally (in person, by telephone) or in writing to the Data controller of Colonnade Insurance S.A. (email: dpo@colonnade.hu, Mailing address: 1426 Budapest, Pf.: 153)

e) The client shall have the right to lodge a complaint before the supervisory authority (NAIH; H - 1055 Budapest,Falk Miksa u. 9-11. ; Mailing address: 1363 Budapest, Pf. 9.; Phone number: (+36) 1 391 1400, Fax: (+36) 1 391 1410, E-mail: ugyfelszolgalat@naih.hu, Web: naih.hu) about the handling his or her complaint or objection relating to the personal data carried out by Controller, or if the client finds any violation relating to the processing of the personal data or an immediate risk of that.

The client shall have the right to submit the claim to the Court. Cases related to data protection fall within the scope of regional courts. Litigation depending from the plaintiff's choice may be initiated before the regional court competent for the plaintiff's permanent or habitual residence.

f) The data subject shall have the right to receive the personal data concerning him or her, which he or she has provided to a controller, in a structured, commonly used and machine-readable format and have the right to transmit those data to another controller without hindrance from the controller to which the personal data have been provided. The client shall have the right to have the personal data transmitted directly from one controller to another, where technically feasible.

Further data processing activity

If the Insurance Company shall provide information to the Authority specified in Section 138, Bit having regard to the personal data, the Insurance Company shall inform the data subject about the recipient and the grounds of the data. The Insurance company shall not be authorized to notify the data subject when data is disclosed pursuant to Paragraphs b), f) and j) of Subsection (1) of Section 138 or Subsection (6) of Section 138, Bit.

Controller shall only provide the requested data in case the actual purpose and the datasets concerned are clearly indicated by the authority, and shall only provide data that is strictly necessary for fulfilling the purpose of the request.

Notification of a Personal Data Breach to the Supervisory Authority, Communication to the Data Subject

In the case of a personal data breach, Controller shall without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the competent supervisory authority, unless the personal data breach is unlikely to result in a risk to the rights and freedoms of natural persons. Controller records any personal data breaches, comprising the facts relating to the personal data breach, its effects and the remedial actions taken.

Controller shall communicate the personal data breach to the data subjects without undue delay if the personal data breach is likely to result in a high risk to the rights and freedoms of the concerned data subjects.

In addition to the above, Controller takes every possible measure to avert the personal data breach in the most efficient way and to ensure the protection of personal data at the highest level.

2.24 Governing Law and Jurisdiction

This policy is a contract of insurance between the Policyholder and the Company. It will be governed by the laws of Hungary and will be subject to the exclusive jurisdiction of Hungarian Courts.

2.25 Complaints

The Company will make every effort to ensure that the *Policyholder* or an *Insured Person* receives a good standard of service. Should any complaint arise with regard to the services or the fulfilment of the insurance contract, we undertake the obligation to inform our client on the right to submit a complaint in writing to the Colonnade Insurance S.A. Hungarian Branch Office via post, e-mail or facsimile (postal address: 1426 Budapest, Pf. 153.; telefax: 06 1 460 1499; e-mail: info@colonnade.hu, web page: https://colonnade.hu/ugyintezes/panaszbejelentes/) and in person or

via telephone at the Customer Service of the Insurance Company during opening hours (address: 1139 Budapest, Váci út 99.; telefonszám: 06 1 460 14000).

The Insurance Company shall send its answer in writing to the complainant within 30 (thirty) days of receipt of the complaint.
In case of the rejection of the complaint or if the 30 day period for the examination of the complaint prescribed by law as the deadline for response ends abortively, the client not qualifying as a consumer may apply to the Court. In this case, the lawsuit must be filed against the Hungarian Branch of Colonnade Insurance S.A. before a Hungarian court with jurisdiction and competence.

The Insurer's complaint handling policy can be viewed at the Customer Service and is also available at the following address: htp://www.colonnade.hu.

The language of client declaration and communication
The contact and information between the *Insurer* and *Insured Person* occurs in Hungarian, and information shall be made available free of charge.

The insurance company does not provide advice about the insurance products sold.

2.26 The language
The language of the insurance policy is English

3. ARTICLE 3 – GENERAL EXCLUSIONS

The Company shall not pay any benefit if related to:

- **Suicide, attempted suicide or self-inflicted injury.**
- **Excessive consumption of alcohol (higher than 0.8‰ alcohol in the blood), misuse of medication, or use of narcotics, illegal drugs or agents.**
- **Learning difficulties or developmental disorders.**
- **Participation in any professional sport.**
- **Aviation or aeronautics other than as a passenger in a properly licensed aircraft.**
- **Loss or Damage directly or indirectly occasioned by, happening through or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any government or public or local authority.**
- **Disabilities while serving in any branch of the military or armed forces of any country, or international authority while on duty, or participation in War, civil war, invasion, insurrection, revolution, use of military power, usurpation of government or military power, or Participation in an actual or attempted riot or any loss directly or indirectly caused by or attributable to any criminal or intentional illegal act or the Insured Person or Policyholder breaking any government laws and regulations or any known or suspected terrorist act.**
- **Any disability, damage or legal liability sustained directly or indirectly by the insured person if the insured person is a terrorist or a member of a terrorist organisation, or a narcotics trafficker, or a purveyor of nuclear, chemical or biological weapons;**
- **If, by virtue of any law or regulation which is applicable to the Company, the parent company or the ultimate controlling entity, at the inception of this Policy or at any time thereafter, providing coverage to the company is or would be unlawful because it breaches an applicable embargo or sanction, the Company shall provide no coverage and have no liability whatsoever nor provide any defense to the Company or make any payment of**

defense costs or provide any form of security on behalf of the Company to the extent that it would be in breach of such embargo or sanction.

SECTION A – CORE PLAN

4. ARTICLE 4 – MEDICAL EXPENSES

4.1 Claims Procedure

Contact information:

The Medical Plan Administrator
24/365 telephone number: **(+351) 21 829 03 70**
Email: colonnade.expat@henner.com
Website: http://www.henner.com

An ID will be communicated to the Insured Person with the Welcome Package.

Non-Emergency Hospitalization and Outpatient Surgery need pre-certification from the Medical Plan Administrator. The Medical Plan Administrator will guarantee the medical expenses to the Hospital.

The Insured Person must pay other expenses to the provider and submit a claim for reimbursement in writing to the Medical Plan Administrator within 90 days of the Date of Service.

Claim forms can be obtained by contacting the 24/365 telephone number or can be found on the website. The claim form must be completed and sent to the Medical Plan Administrator together with the original documentation, invoices and receipts (photocopies or scans are not accepted).

In case the Insured Person can claim from the National Health Service or any other insurance policy, he should first request reimbursement from that organization. The Insured Person shall afterwards forward the original settlement confirmation from that organization with photocopy of the submitted documentation, invoices and receipts to the Medical Plan Administrator. The Medical Plan Administrator shall deduct the amounts that are or could have been received from that organization.

4.2 Medical Expense Benefits

This Policy shall provide cover:
- within the limitations stated in the policy and the policy schedule;
- for the actual, Reasonable and Customary Expenses incurred by the Insured Person;
- for the services listed below;
- that directly relate to a covered Injury or Illness suffered by the Insured Person;
- that are prescribed and certified Medically Necessary by the attending Physician;
- that are general accepted and scientifically recognized medical services, excluding any experimental or pioneering services; and
- that have a Date of Service during the Benefit Period.

Insured services in case of:

a) Hospitalization & Outpatient Surgery:
- Hospital accommodation costs including general nursing in a Standard Private Room.
- Parental Accommodation costs for one parent or legal guardian staying with an Insured Person who is under 18 years of age.

- Expenses related to theatre fees; intensive care; medical imaging; diagnostic and laboratory tests; prescribed medicines and drugs, blood and plasma; surgical appliances; rental of medical aids; surgical appliances.
- Fees of Physicians, including anesthetist, surgeon, specialist, radiologist, physiotherapist and pathologist fees.
- Fees of Physicians for Pre-and Post-Hospitalization Services.

b) Hospital Cash Benefit:

- Benefit per night for the Insured Person that stays as inpatient for more than 48 hours in a Hospital. The benefit is limited to 30 nights per policy year.
- The benefit per night will be doubled in case of a coma.

c) Outpatient Benefit:

- Fees of a family Physician.
- Fees of Physicians and specialist consultations.
- Prescribed Medicines and Drugs that cannot be purchased without prescription.
- Medical imaging, diagnostic and laboratory tests, and surgical appliances.
- Medical aids.
- Non-experimental preventive care and examinations.
- Complementary medicine.

d) Local Ambulance:

- Local Emergency medical transport.

e) Private Nursing Benefit:

- Inpatient in hospital or nursing home.
- Home nursing costs by a Registered Nurse, up to 60 days per policy year.
- Palliative Care.

f) Maternity and Childbirth Benefit:

- Expenses covered under the points “a” to “e” above that are related to:
  - Pregnancy, prenatal, childbirth and post-natal treatment,
  - Complications of Pregnancy, and
  - Congenital Conditions.
- These benefits are limited to costs resulting from pregnancy and childbirth after the first 10 months following the Effective Date of the cover for the mother, unless the waiting period was waived by the Company because of a Preceding Policy.

g) Cancer Treatment Benefit:

- Expenses covered under the points “a” to “e” above that are related to cancer inpatient and outpatient treatment, including specialist fees, medical imaging, diagnostic and laboratory tests, radiotherapy, chemotherapy and hospital charges.

h) Organ Transplant Benefit:

- Expenses covered under the points “a” to “e” above that are related to operations, treatments and testing involved with the transplantation of organs from a human donor.
- The Policy does not cover the costs of acquisition of the organ or expenses incurred by the donor, except for direct costs of surgery to remove such organ for transplantation but not to exceed 30% of the total treatment costs.

i) Mental and Behavioral Disorders Benefit:

- Expenses covered under the points “a” to “e” above that are related to the treatments of mental and behavioral disorders.

- The inpatient treatment is limited to Mental and Behavioral Disorders that begin more than 10 months after the Effective Date of the cover, unless the waiting period was waived by the Company because of a Preceding Policy.
- The outpatient treatment is limited to mental and behavioral disorders that begin more than 18 months after the Effective Date of the cover, unless the waiting period was waived by the Company because of a Preceding Policy.

j) AIDS/HIV Benefit:

- Expenses covered under the points "a" to "e" above that are related to the treatment of Human Immunodeficiency Virus ("HIV") related illnesses including Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex and/or any mutation, derivation, or variation thereof which manifests itself for the first time after the Effective Date of the cover.

k) Emergency Dental Benefit:

- Expenses covered under the points "a" to "e" above that are related to emergency dental treatment required for Accidental damage to Sound Natural Teeth.

l) Emergency Vision Benefit:

- Expenses covered under the points "a" to "e" above that are related to emergency vision treatment required for Accidental damage to an eye.

4.3 Medical Service Provider Referral

The Medical Plan Administrator can refer the Insured Person, upon request, to a suitable Hospital. The information can be obtained by contacting the 24/365 telephone number or can be found on the website.

While the Medical Plan Administrator exercise care and diligence in selecting the Medical Service Providers, the Company or the Medical Plan Administrator cannot guarantee and is not responsible for the service obtained from the Medical Service Providers.

4.4 Exclusions

The Company shall not pay any benefit if related to:

- **Any insured services not explicitly listed under the Medical Expense benefit section.**
- **Vitamins and minerals (except if prescribed and certified Medically Necessary by the attending Physician to treat significant vitamin or mineral deficiency syndromes), nutritional and dietary supplements, baby food.**
- **Cosmetic Surgery.**
- **Reconstructive Surgery, unless the treatment is Medically Necessary and carried out as part of the original treatment of the Congenital Conditions, developmental abnormalities, Injury or Illness.**
- **Relieving symptoms caused by ageing, puberty or other natural physiological cause.**
- **Outpatient treatment of sleep disorders.**
- **Treatment of weight loss or weight problems.**
- **Mental and Behavioral Disorders listed as F10 till F19, F45, F52, F55, F59 or F99 in the International Classification of Diseases of the World Health Organization.**
- **Expenses incurred where an Insured Person has not followed the medical advice of the Physician.**
- **Experimental or pioneering techniques.**
- **Products that can be obtained without a Physician's prescription.**
- **Any sexual problem including impotence (whatever the cause), sex change or gender reassignment.**
- **Venereal Diseases.**
- **Cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.**
- **Fertility, complications or Illness from IVF induced pregnancy, impotence or erectile dysfunction, contraception, sterilization, elective cesarean, or termination of pregnancy that is not Medically Necessary.**
- **Dental and vision treatment, except the Emergency Dental Benefit and the Emergency Vision Benefit as mentioned above.**

- **Batteries, electricity, maintenance expenses and recharging of appliances or medical aids (including hearing and visual aids).**
- **Transfer, transport or travel expenses (except those for local Emergency medical transport or insured under the Assistance benefit).**

5. ARTICLE 5 – ASSISTANCE

5.1 Claims Procedure

Contact information:
Assistance Centre for Colonnade Insurance S. A. Branch Office in Hungary
24/365 Telephone Number: +36 1 460 1500

The Assistance Centre operates a telephone emergency service that is staffed 24 hours a day, 365 days a year by multilingual assistants who are familiar with the procedures of medical and other assistance.

Medical Staff:
The Assistance Centre has a team of highly qualified medical advisers who are available to provide advice regarding the most appropriate assistance and treatment.

The Assistance Centre must be contacted as soon as possible.

When assistance is required, the following information must always be provided to The Assistance Centre:

a) Concerning the Insured Person:
- The name of the Insured Person,
- The telephone number on which the Insured Person can be contacted
- The address where the Insured Person is staying.

b) Concerning the Policyholder:
- The name of the Policyholder,
- The policy number.

c) The nature of the incident.

5.2 Medical Advice over Phone

The Assistance Centre will arrange medical advice over the phone.

5.3 Second Opinion Benefit

The Assistance Centre will help and guide the Insured Person in order to obtain 2 independent reviews of his medical file relating to an insured Illness or Injury. Those second opinions intend to assist the Insured Person and the attending Physician to decide upon the diagnosis and/or treatment protocols.

A second opinion consists of:
- A written evaluation of the Insured Person's medical file and supporting diagnostic information by appropriate specialists or sub-specialists.
- In complex cases, two independent second opinions.
- One follow-up written evaluation, if necessary, of additional reports or questions which are related to the initial second opinion request, obtained within 30 days of the first evaluation.
- A written report providing a diagnosis and/or treatment plan.

To obtain the Second Opinion, the Insured Person or his attending Physician should compile a complete, concise and

recent medical record. The record must be typed in English. The record must at least include:

- Clinical reasons and objectives for the requested review.
- Recent physical examination report.
- Detailed history of present Illness or Injury (including signs, symptoms, chronological onset, diagnosis, treatment plan, response to treatment and current status of disease).
- Medical images and pathology samples, when appropriate with original reports, and laboratory results.
- Brief medical history (including daily routines, habits, surgeries, list of medications, chronic problems, allergies, and relevant family history).

The Assistance Centre shall pay for the reasonable costs of preparing the medical report, subject to prior approval for any such costs being obtained from the Assistance Centre.

5.4 Country Guides

The Insured Person will have access to the country information. This is information on Hospitals and healthcare professionals.

The country information can be found on the website www.henner.com

5.5 Assistance Benefits

Assistance Centre shall use its best endeavours to provide assistance services, but any help and intervention depends upon, and is subject to local availability and has to remain within the scope of national and international law and regulations and intervention depends on Assistance Centre obtaining the necessary authorizations issued by the various authorities concerned.

Assistance Centre shall not be required to provide assistance services to the Insured Person, who is located in areas which represent war risks, political or other conditions that make assistance services impossible or reasonably impracticable.

The Insured Person is provided with the following assistance services:

1. **Monitoring of Medical Condition**
   Upon request, the Assistance Centre monitors the Insured Person's medical condition during hospitalization and keeps the relatives informed. The service is subject to the obligations in respect of confidentiality and relevant authorization.

2. **Emergency Medical Evacuation**
   The Assistance Centre shall organize and pay for, in accordance with the advice of its Medical Consultants, in case of an insured Injury or Illness that needs the emergency medical evacuation of the Insured Person to a more suitable and better-equipped local Hospital. Depending on the seriousness of the circumstances, the person is transported by air ambulance, a scheduled flight, an ambulance or any other means of transport, and if necessary under the supervision of a medical team that has the necessary medical equipment at its disposal. The Medical Consultants of the Assistance Centre shall decide, if necessary in consultation with the local Physician in attendance, if evacuation is needed, with which mode of transport and to what hospital.

   In case the Insured Person was evacuated outside his Home or Host Country, the Assistance Centre shall organize and pay for the return the Insured Person to his Home or Host Country.

3. **Compassionate Visit**
   If the Insured Person is hospitalized for an insured Illness or Injury outside his Home Country and is not accompanied by relatives, the Assistance Centre shall arrange in consultation with the Insured Person, the Physician and the relatives of the Insured Person for a relative to travel and stay with the Insured Person during the time of the

hospitalization. In addition, the Assistance Centre shall pay this relative's expenditure for travel and visa documents, transport, accommodation, taxi, telephone and childcare, incurred on the advice of the Medical Consultants of Colonnade Atlasz Assistance and within the limitations of the policy.

4. **Return of Children**
   The Assistance Centre shall organize and pay for the escorted return of an under age Insured Persons to the Home or Host Country if the children are left unattended as the result of an insured Illness or Injury of the accompanying Insured Person.

5. **Delivery of Essential Medication**
   At the request of the Insured Person and in case of an emergency, the Assistance Centre shall assist in finding and sending essential medication or medical equipment if these are not available locally. The Assistance Centre shall pay for the shipping cost. In non-emergency cases, Assistance Centre can provide the same service but at the cost of the Insured Person.

6. **Assistance in case of Death**
   If the Insured Person dies, the Assistance Centre shall organize and pay for transportation of the mortal remains or the ashes, including the cost of the coffin needed for transport, and for transportation of the personal belongings of the Insured Person to his Home Country.
   The Assistance Centre shall also organize and pay for the flight to the Home Country of the insured Dependants.

7. **Interpreter Referral**
   At the request of the Insured Person, the Assistance Centre assists the Insured Person in finding an interpreter.

8. **Legal Referral**
   At the request of the Insured Person, the Assistance Centre refers him to an embassy, consulate or other organization, including a lawyer who speaks the required language, if legal assistance is required.

5.6 Limitations & Exclusions

The benefit in case of flights is limited to public transport in economy class, unless the Medical Consultants of the Assistance Centre decide otherwise.

The Company shall not pay any benefit:

- **For services that were not organized or approved in advance by the Assistance Centre.**
- **If the purpose of the trip is to obtain medical treatment or medical advice, unless in the course of an approved Emergency Medical Evacuation.**
- **If the Insured Person is traveling against the advice of a Physician.**
- **For services that are excluded in the Medical Expense cover or have their Date of Service during a waiting period mentioned under the Medical Expense cover.**

6. ARTICLE 6 – POLITICAL EVACUATION

6.1 Cover

The Company shall pay the cost of evacuation up to a maximum of EUR 50,000, or the sum insured stated in the policy schedule if different, per policy period for the Expatriate Employee and their Dependants together.

The Company shall use its best endeavours to provide political evacuation cover, but any help and intervention depends upon, and is subject to local availability and has to remain within the scope of national and international law and regulations and intervention depends on the Company obtaining the necessary authorizations issued by the various authorities concerned.

The Company shall not be required to provide political evacuation cover to the Insured Person, who is located in such areas which represent war risks, political or other conditions that make such evacuation impossible or reasonably impracticable.

6.2 Conditions

6.2.1 Evacuation

The cover is provided for the following unforeseen events, insofar as these take place outside the control of the Policyholder and the Insured Person, and which require the immediate evacuation of the Insured Person:

a) an Insured Person is banned or declared a persona non grata by the authorities of the recognized government of the Host Country, or

b) the Ministry of Foreign Affairs or a comparable authority of the Home Country or the country of the Policyholder recommend evacuation due to political or military activities in the Host Country or in which a Host Country is involved within 10 days prior to the evacuation.

6.2.2 Cost of Evacuation

The reasonable and inevitable costs incurred by the Policyholder or the Insured Person for the evacuation of the Insured Person to the nearest safe place and for repatriation of the Insured Person to his Home Country. This also includes reasonable transport and accommodation expenses incurred by the Policyholder and the Insured Person during the evacuation for a maximum period of two days.

6.3 Exclusions

No cover is provided for evacuation costs:

- **for which the Policyholder as an employer is liable or which the Policyholder has to bear pursuant to legislation pertaining to unemployment, accident, illness, absenteeism or incapacity for work.**
- **arising from a fraudulent, dishonest or criminal act, and committed or attempted by a Policyholder, an Insured Person or an authorized representative of one of them, acting alone or in a conspiracy with others.**
- **arising from violation of the laws of the Host Country by the Policyholder or by an Insured Person.**
- **arising from the Insured Person not possessing valid travel documents and a valid visa.**
- **arising from debt, insolvency, business failure, the exercise of any right of retention or security right, or another financial cause.**
- **arising from Illness, death or Injury of an Insured Person.**

7. ARTICLE 7 – THIRD PARTY LIABILITY

The Insurer will indemnify an Insured Person for any legal liability incurred by that Insured Person during a trip during the Operative Time and Period of Insurance as the result of Bodily Injury or Sickness of any person, or accidental loss or damage to the property of any person, up to the sum insured in the schedule which is an aggregate limit for all losses under this policy occurring during each Period of Insurance.

The sum insured stated on the policy schedule is the limit of the Company's liability for all losses, including losses for care and loss of services, as the result of any one occurrence.

The term Insured Person is used severally and not collectively, but the inclusion herein of more than one Insured Person shall not operate to increase the limits of the Company's liability. The Company's total liability under Third Party Liability for all losses resulting from any one occurrence shall not be more than the sum insured stated on the policy schedule. This limit is the same regardless of the number of Insured Persons, claims made, or persons injured. All Injuries and property damage resulting from continuous or repeated exposure to substantially the same general harmful conditions shall be considered to be the result of one occurrence.

The Company's total liability for all medical expenses payable for Injuries to one person as the result of one Accident will not be more than the sum insured stated on the policy schedule.

7.1 The Company will indemnify the Insured Person for sums which the Insured Person shall become legally obligated to pay due to Injury or Illness sustained by any person, including death at any time resulting there from, and as a loss due to damage to or destruction of property, including the loss of use thereof.

The Company will also cover the Insured Persons liability to pay Reasonable and Customary Expenses incurred within one year from the date of Accident for necessary medical, surgical and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services, to or for each person who sustains Injury or Illness caused accidentally:

a) while on the Insured Premises with the permission of an Insured Person;

b) while elsewhere if such Injury or Illness:

- **1)** Was caused out of the Insured Premises but due to conditions linked with the insured premises;
- **2)** Is caused by the activities of an Insured Person;
- **3)** Is caused by the activities of or is sustained by a Residence Employee, while engaged in the employment of an Insured Person.
- **4)** Is caused by an animal owned by or in the care of the Insured Person.

7.2 Defense Settlement and Supplementary Payments

With respect to such insurance as is afforded by this policy for liability coverage, the Company shall:

7.2.1 Cover any defense expenses occured any suit against the Insured Person alleging such Injury, Illness, damage or destruction and seeking losses on account thereof, even if such suit is groundless, false or fraudulent; but the Company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient;

With the respect to liability of the Insured Person to indemnify the sums which the Insured Person shall become legally obligated to pay as damages to the sustained person, the Company shall pay the following supplementary payments:

a) Premiums on bonds to release attachments for amounts not in excess of the applicable limit of the policy coverage, premiums on appeal bonds required in any such defended suit, but without any obligation to apply for or furnish any such bonds;

b) Expenses incurred by the Company, costs taxed against the Insured Person in any such suit and interest accruing after entry of judgment until the Company has paid or tendered or deposited in court such part of such judgment as does not exceed the limit of the Company's liability thereon;

c) Expenses incurred by the Insured Person in the event of an Accident causing Injury or Illness, for such immediate medical and surgical relief to others as shall be imperative at the time of the Accident; or

d) All reasonable expenses, other than loss of earnings, incurred at the Company's request. And the amounts so incurred, except settlements of claims and suits, are payable by the Company in addition to the applicable limit of liability of this policy.

7.3 Provisions applicable to Article 7

1) In addition the *Insurer* will pay all costs and expenses incurred with the written consent of the *Insurer* in connection with the defence of any claims against an *Insured Person* which may be the subject of indemnity under this Section.

2) No admission of liability, offer, promise or payment will be made without the written consent of the *Insurer*.

3) The *Insurer* will, if it considers it necessary, take over and conduct the defence or settlement of any claim against an *Insured Person* and for that purpose can use the *Insured Person's* name. The *Insurer* can conduct the defence however it sees fit. The *Insurer* can prosecute at its own expense and for its own benefit, any claim for indemnity or damages against any other persons.

4) The *Insured Person* will give the *Insurer* full assistance in defending or prosecuting any claim and will provide the *Insurer* with any information and documents available to him.

7.4 Exclusions applicable to Article 7

The Insurer will not pay for any liability which is the result of:

1) Bodily injury to, or illness or disease of, any person who is an employee of the *Policyholder* or an *Insured Person* when injury results from their employment by the *Policyholder* or an *Insured Person*,

2) Liability arising directly or indirectly by or through, or in connection with, any motorised craft.

3) Liability arising directly or indirectly by or through or in connection with:

- **a) the ownership, possession or occupation of land,**
- **b) any deliberate or unlawful act,**
- **c) the carrying on of any trade, business or profession,**
- **d) any racing activity,**

4) Accidental loss or damage to property belonging to, held in trust by, or in the custody or control of the *Policyholder* or an *Insured Person* or any of their employees or any member of an *Insured Person's* family or household,

5) Liability attaching to the *Policyholder* or an *Insured Person* under an express term of any contract, unless liability would arise whether or not the express term existed,

6) Liability for which payment should be more specifically claimed under any other contract of insurance in the name of the *Policyholder* or an *Insured Person,*

7) Any claim where an *Insured Person* is insane or which results from an *Insured Person* being under the influence of or affected by drugs (other than drugs taken under the direction of a *Medical Practitioner*), alcohol, or solvents,

8) Any claim resulting from any Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related condition, or sexually transmitted disease suffered by an *Insured Person*

9) Liability in respect of fines, penalties or liquidated damages, punitive exemplary or aggravated damages.

7.5 Claims Procedure

7.5.1 When an occurrence takes place, written notice thereof shall be given by or on behalf of the Insured Person as soon as practicable to:

Colonnade Insurance S. A. Branch Office in Hungary
1426 Budapest, Pf. 153.
Telephone number: +36-1-460-1500
e-mail: assistance@colonnade.hu

Such notice shall contain the identity of the policy and Insured Person, reasonably available information on the time, place, and circumstances of the Accident or occurrence and names and addresses of any claimants and witnesses. At the request of the Company, the Insured Person shall help the Company to make settlement, enforce any right of contribution or indemnity against any person or organization who may be liable to an Insured Person, with the conduct of suits and attend hearings and trials and to secure and give evidence and obtain the attendance of witnesses.

7.5.2 If claim is made or suit is brought against the Insured Person, the Insured Person shall immediately forward to the Company every demand, notice, summons or other process received by the Insured Person or his representative. The proceeding should be instituted within the prescriptive period settled by the legislation of the local law or within one year from the date of loss if any other legislation is applicable to the policy.

7.5.3 The Insured Person shall cooperate with the Company and upon the Company's request, shall attend hearings and trials and shall assist in effecting settlements, securing and giving evidence obtaining the attendance of witnesses and in the conduct of suits. The Insured Person shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be imperative at the time of the Accident.

7.5.4 No action shall be taken against the Company unless, as a condition precedent thereto, the Insured Person shall have fully complied with all the terms of this policy, nor until the amount of the Insured Persons obligation to pay shall have been finally determined either by judgment against the Insured Person after actual trial or by written agreement of the Insured Person, the claimant and the Company. Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy. Nothing contained in this policy shall give any person or organization any right to join the Company as a co-defendant in any action against the Insured Person to determine the Insured Person's liability. Bankruptcy or insolvency of the Insured Person or of the Insured Person's estate shall not relieve the Company of any of its obligations hereunder.

8. ARTICLE 8 – LEGAL ASSISTANCE

8.1 Cover

Legal assistance: The Company shall indemnify the Insured Person for the costs of Legal Expenses in connection with causes of action outside his Home Country arising during the Benefit Period, up to a maximum of EUR 15,000, except in the case of charges for or indictments for a criminal offense, in which case the maximum will be EUR 5,000. There is a deductible of 10% with a minimum of EUR 250.

Bail bond: In the event that the Insured Person is placed in or is threatened to be placed in detention outside his Home Country during the Benefit Period, the Company shall pay a bail bond up to a maximum of EUR 50,000. The Insured Person shall repay this sum within 3 months of the date of payment, or immediately upon repayment by the authorities or if the bail bond is forfeited by failure to appear in court, unless the latter could not reasonably be expected of the Insured Person.

8.2 Stipulations

- The Company has to consent to the intended action beforehand. Such consent is given if the Insured Person can convince the Company that:

- there are reasonable grounds for an action and,
- that the cost of legal assistance are reasonable.

- The Company shall take into account the opinion of the Representative hired by the Insured Person and of its own advisers. If the Company agrees to the proposed action, the Company shall pay the reasonable costs which the Insured Person has incurred in order to obtain such opinion.
- All claims and legal procedures, including any appeal arising from the same event or circumstances, are regarded as a single claim.
- If the action is successful, any legal costs awarded shall accrue to the Company up to the amount that the Company has paid in this respect.

8.3 Exclusions

The Company shall not pay any benefit if related to:

- **an intentional crime, an offence against property or an offence against narcotics legislation committed by the Insured Person.**
- **a claim from or against the Policyholder, the Company, or any organization or person who is involved in this insurance.**
- **business activities,**
- **contractual issues,**
- **family and succession law issues,**
- **liabilities arising out or in relation to compulsory insurance.**

8.4 Claims Procedure

Contact information:
Colonnade Insurance S.A. Branch Office in Hungary
1426 Budapest, Pf. 153.
Telephone number: +36 1 801 08 01
e-mail: assistance@colonnade.hu

SECTION B – OPTIONAL BENEFITS

9. ARTICLE 9 – PERSONAL ACCIDENT PLAN

The optional Personal Accident Plan can only be taken insofar as the Insured Persons are covered by the Core Plan and only on a family level, i.e. for the Expatriated Employee and his Dependants together.

9.1 Definitions

9.1.1 **Accumulation Limit** means the total maximum amount the Company will pay in the aggregate under this and any other accident insurance policy issued by the Company for Injuries suffered by all Insured Persons in the same Accident or series of Accidents contributed to, caused by or consequent upon the same original cause, event or circumstance.

9.1.2 **Deferment Period** means the initial period of Temporary Disablement during which the benefit on the policy schedule is not payable.

9.1.3 **Loss of Hearing** means total and permanent loss of hearing.

9.1.4 **Loss of Limb** means:
In the case of a leg or lower limb:
a) loss by permanent physical severance at or above the ankle, or
b) permanent and total loss of use of a complete foot or leg.

In the case of an arm or upper limb:
a) loss by permanent physical severance of the four fingers at or above the meta carpo phalangeal joints (where the fingers join the palm of the hand), or
b) permanent and total loss of use of a complete arm or hand.

9.1.5 **Loss of Sight** means permanent and total loss of sight in both eyes, or in one eye if the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.

9.1.6 **Loss of Speech** means total and permanent loss of speech.

9.1.7 **Paraplegia** means the permanent and total paralysis of the two lower limbs, bladder and rectum.

9.1.8 **Permanent Disablement** means permanent total or partial loss or disablement of any limb or organ (or a part thereof).

9.1.9 **Quadriplegia** means the permanent and total paralysis of the two upper limbs and two lower limbs.

9.1.10 **Temporary Disablement** means an Injury that prevents the Insured Person from carrying out all parts of his usual and paid professional occupation.

9.2 Accidental Death

If the Insured Person had an insured Accident during the Benefit Period and dies within two years as a direct and sole consequence of that Accident, the sum insured stated in the policy schedule is paid out.

The payment is made as soon as the investigation by the Company into the Accident, the cause of death and the connection between the two has been completed. All sums already paid out on this insurance policy for Permanent

Disablement as a result of the same Accident are deducted from this payment.
If an Insured Person is missing and after an appropriate period of time it can reasonably be assumed that the Insured Person has died as the result of Injury, the sum insured stated on the policy schedule is paid out. In that case, the Beneficiary is required to sign an agreement stating that if it transpires later that the Insured Person has not died, any benefits received are repaid to the Company.

The sum insured for the death of an under age Insured Person is limited to EUR 15,000.

9.3 Permanent Disablement

In the event of Permanent Disablement as a result of an insured Accident during the Benefit Period, the Company shall pay out the percentages of the sum insured applicable to Permanent Disablement as set out below.

The degree of Permanent Disablement is assessed as soon as it has reasonably been concluded that the condition of the Insured Person is not likely to improve or deteriorate, but not later than two years after the Accident.

In the event that the Insured Person dies before the percentage has been determined, the Company is not obliged to pay any Permanent Disablement benefit. However, if the Insured Person dies more than 6 months after the Accident but not as a result of the Accident, the Company shall pay the amount that it would reasonably have expected to pay out for Permanent Disablement had the Insured Person not died.

In order to determine the percentage of disablement, the following disablement scale is used:

Permanent complete loss or permanent total disablement of:	Percentage of disablement:
• at least one limb	100%
• loss of eyesight	100%
• total paralysis	100%
• incurable major brain damage	100%
• loss of speech	100%
• hearing in both ears	100%
• hearing in one ear	25%
• sense of touch or smell	10%
• a thumb	30%
• an index finger	20%
• other finger	10%
• a big toe	15%
• other toe	5%
• spleen	5%
• kidney	20%
• a shoulder or an elbow	25%
• a wrist, hip, knee or ankle	20%
• lower jaw as a result of surgical treatment	30%
• the back or spine below the neck without damage to the spinal cord	40%
• the neck or neck vertebrae without damage to the spinal cord	30%

In the event of partial permanent loss or partial permanent disablement, a proportionate part of the percentage stated for complete loss or total disablement is paid out pro rata to the seriousness of such loss or disablement.

If a claim is payable for loss of or disablement of a whole part of the body, a claim for any component of that part cannot also be made.

In the event of disablement of several limbs or organs as a result of one or more Accidents, payment shall never exceed

100% of the sum insured for total Permanent Disablement.
When determining the percentage, any Permanent Disablement existing prior to the Accident are deducted from this percentage.

In the event of loss or disablement of any body parts, organs, etc. not listed above, the percentage is based on the general scale used in the medical sector, in which case the Insured Person can also opt for the following:

a) his employment must not be taken into account;

b) his employment and the activities he customarily performed prior to the Accident must be taken into account; considering also any suitable employment that may in all reasonableness be required of him regarding his disabilities, strengths, capabilities, education and social position.

9.4 Temporary Disablement

In the event of Temporary Disablement as a result of an insured Accident during the Benefit Period, the Company shall pay out the weekly sum insured as mentioned on the policy schedule.

The weekly sum insured will be payable for every full week after the Deferment Period as mentioned on the policy schedule, until the Insured Person can resume his usual and paid professional occupation, until the degree of Permanent Disablement is assessed, or until the number of weeks mentioned on the policy schedule is passed, whichever occurs first.

In case the Insured Person relapses within a period of 3 months because of the same Accident, the period of Temporary Disablement will be considered as a continuation of the previous period and no new Deferment Period will be applied.

The benefit shall not be payable if the Insured Person has no usual and paid professional occupation or if the Temporary Disablement has no impact on the remuneration.

9.5 Additional Benefits

An additional benefit is paid in the following cases:

9.5.1 Paraplegia & Quadriplegia

In the event of Paraplegia or Quadriplegia, the following benefit is added to the benefit for Permanent Disablement:

- Paraplegia: EUR 25,000
- Quadriplegia: EUR 50,000.

9.5.2 Dependant Children

In the event that a payment is made for Accidental Death by Accident, the amount to be paid is increased by EUR 5,000 for each insured Dependant child of the Insured Person, up to a maximum of 20% of the sum insured for Death by Accident.

9.5.3 Retraining Costs

In the event that a payment is made for the loss of a limb or the loss of sight, the Company shall indemnify the Policyholder for the reasonable costs incurred for retraining the Insured Person to carry out suitable employment activities up to a maximum amount of EUR 5,000.

9.5.4 Replacement Costs

In the event that a payment is made for Death by Accident, the Company shall indemnify the Policyholder up to an amount of EUR 5,000 in respect of any reasonable costs incurred for recruiting a replacement for the Insured Person.

9.5.5 Personal Belongings

If an insured Accident results in immediate hospitalization, the Company shall pay for damage to and the cost of lost, damaged or stolen personal belongings as a direct result of the Accident, up to a maximum of EUR 5,000.

9.5.6 Seatbelt

If the Insured Person dies as a result of a road traffic Accident and it has been established that he was wearing a seatbelt at the time, the benefit to be paid is increased by EUR 5,000.

9.5.7 Life Saver

If a third party (not an Insured Person or the Policyholder) sustains Injury while trying to save the life of an Insured Person which subsequently results in the death or Permanent Disablement of this third party within two years of the event, the Company shall pay this third party on the basis of an insured sum of EUR 25,000. This benefit is paid in addition to any benefit paid to the Insured Person.

9.5.8 Home Modifications

In the event that an Insured Person sustains Injury that require modifications to his home in his Home Country (including but not limited to the installation of ramps for external and internal wheelchair access, internal grab rails, emergency alarm system and similar aids) in order to be able to carry out day-to-day activities (such as washing, cooking, bathing and dressing) and to be able to function in and around his home in his Home Country, the Company shall pay 80% of the incurred cost of such adaptations up to a maximum of EUR 5,000. Such adaptations are to be made with prior written permission from the Company and need to be recommended by the Physician treating the Insured Person.

9.6 Claims Procedure

Colonnade Insurance S.A. Branch Office in Hungary
1426 Budapest, Pf. 153.
Telephone number: +36 1 801 08 01
e-mail: karrendezes@colonnade.hu

10. ARTICLE 10 – DENTAL & VISION CARE

The optional Dental & Vision Care Plan can only be taken insofar as the Insured Persons are covered by the Core Plan and only on a family level, i.e. for the Expatriated Employee and his Dependants together.

10.1 Claims Procedure

Contact information:

24/365 telephone number: **Tel: (+351) 21 829 03 70**
Email: colonnade.expat@henner.com
Website: http://www.henner.com

(ID will be communicated to the Insured Person with the Welcome Package)

Non-Emergency Hospitalization and Outpatient Surgery need pre-certification from the Medical Plan Administrator. The Medical Plan Administrator will guarantee the medical expenses to the Hospital.

The Insured Person must pay other expenses to the provider and submit a claim for reimbursement in writing to the Medical Plan Administrator within 90 days of the Date of Service.

Claim forms can be obtained by contacting the 24/365 telephone number or can be found on the website. The claim

form must be completed and sent to the Medical Plan Administrator together with the original documentation, invoices and receipts (photocopies or scans are not accepted).

In case the Insured Person can claim from the National Health Service or any other insurance policy, he should first request reimbursement from that organization. The Insured Person shall afterwards forward the original settlement confirmation from that organization with photocopy of the submitted documentation, invoices and receipts to the Medical Plan Administrator. The Medical Plan Administrator shall deduct the amounts that are or could have been received from that organization.

10.2 Definitions

10.2.1 **Dental prosthesis** means crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment and repairs required.

10.2.2 **Dentist** means a properly qualified medical practitioner who is licensed to render dental treatment by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his licensing and graduation.

10.2.3 **Routine Dental Treatment** means dental examinations, tooth extractions, tooth cleaning, normal compound filling, root canal treatment, paradental treatment, paradontosis treatment, gum treatment, and X-ray examinations.

10.2.4 **Major Restorative Dental Treatment** means removal of impacted, buried or unerupted teeth, removal of solid odontomes, and apicectomy.

10.2.5 **Vision Treatment** means ophthalmic examinations and treatments, excluding any eye surgery.

10.2.6 **Eye Surgery** means ophthalmic surgery, such as laser eye surgery, cataract surgery, glaucoma surgery, canaloplasty, refractive surgery, corneal surgery, vitreo-retinal surgery, eye muscle surgery and oculoplastic surgery.

10.2.7 **Optical Devices** means Medically Necessary glasses, frames and contact lenses prescribed by an Ophthalmic Physician

10.3 Dental Care

This Policy shall provide cover:

- within the limitations stated in the policy schedule;
- for the actual, Reasonable and Customary Expenses incurred by the Insured Person;
- for the services listed below;
- that are prescribed and certified Medically Necessary by a Dentist or Dental Physician;
- that are general accepted and scientifically recognized medical services, excluding any experimental or pioneering services; and
- that have a Date of Service during the Benefit Period.

The insured services are:

- Routine Dental Treatment (sums insured listed on the policy schedule);
- Major Restorative Dental Treatment (sums insured listed on the policy schedule);
- Dental Prosthesis (sums insured listed on the policy schedule);
- Orthodontic Treatment (sums insured listed on the policy schedule).

The reimbursement of the expenses is reduced or refused to the extent that the Insured Person’s teeth are deemed

by a Dentist or Dental Physician to be in a considerably worse condition than the teeth of persons of the same age who have at least annual dental checks and receive the recommended dental treatment, or if the cause of the worse condition of the Insured Person's teeth is prior to the Benefit Period.

Indemnity for Major Restorative Dental Treatment, Dental Prosthesis and Orthodontic Treatment is limited to treatments that begin more than 10 months after the Effective Date of the cover for the Insured Person, unless the waiting period was waived by the Company because of a Preceding Policy.
Orthodontic treatment is only covered if started before age 16.

10.4 Vision Care

This Policy shall provide cover:

- within the limitations stated in the policy and the policy schedule;
- for the actual, Reasonable and Customary Expenses incurred by the Insured Person;
- for the services listed below;
- that are prescribed and certified Medically Necessary by the attending ophthalmic Physician;
- that are general accepted and scientifically recognized medical services, excluding any experimental or pioneering services; and
- that have a Date of Service during the Benefit Period.

The insured services are:

- Vision Treatment (sums insured listed on the policy schedule);
- Eye Surgery (sums insured listed on the policy schedule);
- Optical Devices (sums insured listed on the policy schedule).

11. ARTICLE 11 – PERSONAL PROPERTY

The optional Personal Property Plan can only be taken insofar as the Insured Persons are covered by the Core Plan and only on a family level, i.e. for the Expatriated Employee or the Individual Expatriate and his Dependants together.

11.1 Cover

Personal property (including, but not limited to, personal effects, household furniture and household goods) owned or used by an Insured Person, is insured against risk of direct loss caused by a peril listed below, when it is located on the Insured Premises:

11.1.1 Fire and/or lightning.

11.1.2 Windstorm or hail. This peril does not include loss to the property contained in a building caused by rain, snow, sleet, sand or dust unless the direct force of wind or hail damages the building causing an opening in a roof or wall and the rain, snow, sleet, sand or dust enters through this opening. This peril includes loss to watercraft and their trailers, furnishings, equipment, and outboard engines or motors, only while inside a fully enclosed building.

11.1.3 Explosion.

11.1.4 Aircraft, including self-propelled missiles and spacecraft.

11.1.5 Vehicles.

11.1.6 Smoke, meaning sudden and accidental damage from smoke. This peril does not include loss caused by smoke from agricultural smudging or industrial operations.

11.1.7 Vandalism or malicious mischief.

11.1.8 Theft, including attempted theft from a known place. This peril does not include loss caused by theft or attempted theft when the theft is:

a) Committed by an Insured Person;
b) Loss of property when it is unlikely that the property has been stolen;
c) From that part of an Insured Premise rented by an Insured Person to other than an Insured Person;
d) Theft in or to a dwelling under construction including materials and supplies for use in the construction; or
e) Theft of personal property from a motor vehicle or other motorized land conveyance.

11.1.9 Falling objects. This peril does not include loss to property contained in a building unless the roof or an outside wall of the building is first damaged by a falling object. Damage to the falling object itself is not included.

11.1.10 Weight of ice, snow or sleet which causes damage to property contained in a building.

11.1.11 Accidental discharge of water or steam from within a plumbing, heating, air condition or automatic fire protective sprinkler system or from within a household appliance.

11.1.12 Sudden and accidental tearing apart, cracking, burning or bulging of a steam or hot water heating system, an air conditioning or automatic fire protective sprinkler system or an appliance for heating water.

11.1.13 Freezing of a plumbing, heating, air conditioning or automatic fire protective sprinkler system or of a household appliance. This peril does not include loss on the Insured Premises while the dwelling is unoccupied, unless you have used reasonable care to maintain heat in the building, or shut off the water supply and drain the system and appliances of water.

11.1.14 Sudden and accidental damage from artificially generated electrical current. This peril does not include loss to a tube, transistor or similar electronic component.

11.2 Valuables

Unless otherwise specified on the policy schedule, the Company's liability for loss of the following types of property is limited to:

- EUR 300 per occurrence on cash, currency, money, bullion, numismatic property and bank notes. If a loss which is covered under the terms and conditions of this policy consists only in the loss of money, then the deductible specified in the certificate of coverage does not apply.
- EUR 450 per occurrence on manuscripts, securities, accounts, bills, deeds, evidences of debt, letters of credit, notes other than bank notes, passports, railroad and other travel tickets or stamps;
- EUR 1,000 per occurrence for theft of stereo equipment. Stereo equipment includes accessories, antennas, tapes, wires, records, discs or other media for use with any electronic stereo equipment.
- EUR 1,000 per occurrence on coin and philatelic collections, with a limit of EUR 250 for any one stamp, coin or individual article or any one pair, strip, block, series sheet, cover, frame or card.
- EUR 1,500 per occurrence for theft of jewelry, watches, furs, fine arts, antiques, golfers equipment, cameras and computer hardware; and

11.3 Exclusions

11.3.1 Property not covered:

a) Summer cottages, buildings under construction, buildings used for commercial purposes, living accommodations in tenement house, their constructive elements (together or separately);

b) Animals, automobiles, motorcycles, aircraft, boats or other vehicles, or their equipment or furnishings except when the equipment or furnishings are removed from the vehicles and actually located on the Insured Premises of the Insured Person;

c) The property of any Insured Person while he is engaged in any form of professional entertainment, or property relating to a business, profession or occupation of an Insured Person;

d) The property while aboard any overseas vessel or during loading or unloading there from except such property which accompanies an Insured Person as person baggage;

e) The property ordinarily located throughout the year at a residence(s) other than the Insured Premises of the Insured Person;

f) The property on exhibition at fairgrounds or on the premises of any national or international exposition;

11.3.2 Risks not covered:

a) To the marring or scratching of any property or breakage of eyeglasses, glassware, statuary, marble, bric-a-brac, porcelains and similar fragile articles unless such marring, scratching or breakage is caused by theft, burglary or robbery or attempt thereat, vandalism, malicious mischief, fire, lightning, windstorms, cyclone, tornado, hurricane, explosion, falling aircraft, riot, strike, collapse of building or accident to transporting vehicle other than an overseas vessel. The exclusion of breakage does not, however, apply to jewelry, watches, bronzes, photographic equipment or binoculars;

b) To mechanical breakdown; against loss or damage to electrical apparatus caused by electrical breakdown other than lightning, unless fire results and then only for loss or damage by such resultant fire;

c) Against loss or damage occasioned by or through or in consequence, directly or indirectly, of the following occurrences:

1) War or the act of any person acting on behalf of, or in connection with, any organization with activities directed toward the overthrow by force of any government, dejure of defacto, or to the influencing of it by terrorism or violence; or

2) Risks of contraband or illegal transportation or trade, seizure or destruction under quarantine or customs regulations, confiscation by order of any government or public authority.

d) For loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss.

1) Ordinance or law, meaning enforcement of any ordinance or law regulating the construction, repair, or demolition of a building or other structure.

2) Earth movement, meaning earthquake including land shock waves or tremors before, during or after a volcanic eruption; landslide; mine subsidence; mud flow; earth sinking, rising or shifting; unless direct loss by fire or explosion. If the abovementioned caused fire; explosion; or breakage of glass or safety glazing material which is part of a building, storm door or storm window, the Company will indemnify the loss ensued by these occurrences. This exclusion does not apply to loss by theft;

3) Water damage, meaning:

- Flood, surface water, waves, tidal water, overflow of a body of water or spray from any of these, whether or not driven by wind;
- Water which backs up through sewers or drains or which overflow from a sump; or
- Water below the surface of the ground, including water which exerts pressure on or seeps or leaks through a building sidewalk, driveway, foundation, swimming pool or other structure.

Direct loss by fire, explosion of theft resulting from water damage is covered;

4) Power failure, meaning the failure of power or other utility service if the failure takes place off the Insured Premises. But if an insured peril ensues on the Insured Premises, only that ensuing loss will be paid;

5) **Neglect, meaning neglect of the Insured Person to use all reasonable means to save and preserve property at and after the time of a loss;**
6) **Intentional loss, meaning any loss arising out of any act committed by or at the direction of an Insured Person or beneficiary, and with the intent to cause a loss.**

e) Personal property is not insured for loss caused by any of the following. However, any ensuing loss to personal property which is not excluded or excepted in this policy is covered:

1) **Weather conditions. However, this exclusion only applies if weather conditions contribute in any way with a cause or event excluded above to produce the loss.**
2) **Acts or decisions, including the failure to act or decide, of any person, group, organization or governmental body;**
3) **Faulty, inadequate or defective:**
   - **Planning, zoning, development, surveying, siting;**
   - **Design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction;**
   - **Materials used in repair, construction, renovation or remodeling; or**
   - **Maintenance, of part or all of any property.**

11.4 Loss Settlement

11.4.1 The limit of the Company's liability for loss shall not exceed the replacement cost of the property at the time of the loss, up to the limits shown on the policy certificate.

11.4.2 Any loss to any property listed below will be settled at actual cash value at the time of loss but not exceeding the amount necessary to repair or replace:

a) Coin and philatelic collections, antiques, fine arts, paintings, statuary and similar articles which by their inherent nature can not be replaced with new articles;
b) Articles whose age or history contributes substantiality to their value. This includes but is not limited to memorabilia, souvenirs and collectors items;
c) Property which is obsolete or unusable for the purpose for which it was originally intended because of its age or condition;
d) Watercraft, including their trailers, furnishings, equipment and outboard motors when this class of property is covered on the conditions of its location on the Insured Premises;
e) Personal items which are separately described and specifically insured in this or other insurance.

11.4.3 Other property:

a) The Company will pay no more than the least of the following amounts:
   1) replacement cost at the time of loss without deduction for depreciation;
   2) the full cost of repair at the time of loss; or
   3) the specific limit of liability stated in the policy schedule in case of loss, if any.
b) When replacement cost for the entire loss under this coverage is more than EUR 1,500, the Company will not pay more than actual cash value of the damage until repair or replacement is completed;
c) The Insured Person may make a claim under this coverage for loss or damage on an actual cash value basis and then make claim within 180 days after the loss for any additional cost on a replacement cost basis with the condition of proper and complete documentary substantiation and confirmation of such claims.

11.4.4 The Company may pay for the loss in money or may repair or replace the property and may settle any claim for loss of property either with the Insured Person or the owner thereof with the condition that the claimant has a property interest in this property and (or) other foundations for making the claim. Any property so paid for or replaced will become the property of the Company. The Insured Person, Beneficiary or the Company, upon recovery of any such property, will give notice thereof as soon as practicable to the other and the Insured Person or Beneficiary will be entitled to the property upon reimbursing the Company for the amount paid or

the cost of replacement. Any loss there under will not reduce the amount of insurance afforded under the policy. Application of the insurance to property of more than one person shall not operate to increase the Company's liability.

11.5 Claims Procedure

11.5.1 Upon knowledge of loss, the Insured Person or Beneficiary shall give notice thereof as soon as practicable to:

Colonnade Insurance S. A. Branch Office in Hungary
1426 Budapest, Pf. 153.
Telephone number: +36-1-460-1500
e-mail: karrendezes@colonnade.hu

In case of loss by burglary, robbery, theft or larceny, the Insured Person or Beneficiary must notify the police or other official authorities having jurisdiction, and in case of theft of a credit card or fund transfer card, notify the credit card or fund transfer card company. The Insured Person or Beneficiary must also protect the remaining property from further damage, prepare an inventory of damaged personal property showing the quantity, description, actual cash value and amount of loss, attach all bills, receipts and related documents that justify the figures in the inventory.

As often as the Company reasonably require, the Insured Person or Beneficiary must show the damaged property, provide the Company with records and documents requested and permit the Company to make copies.

The Insured Person or Beneficiary must send to the Company, as soon as practicable after the request, a signed, sworn proof of loss which sets forth, to the best of the Insured Person's or Beneficiary's knowledge and belief, the time and cause of loss, the interest of the Insured Person or Beneficiary and all others in the property involved and all liens on the property, other insurance which may cover the loss, changes in title or occupancy of the property during the term of the policy, the inventory of damaged personal property or receipts for additional living expenses incurred and records that supports the fair rental value loss and evidence.

11.5.2 The Insured Person or Beneficiary shall file proof of loss with the Company at the above address as soon as practicable after the discovery of loss. Upon the Company's request, the Insured Person or Beneficiary shall submit (and, so far as is within his or her power, shall cause all other persons interested in the property and household members and employees to submit), to examination by the Company, sign a sworn statement referring to the loss, and produce for the Company's examination all pertinent records at such reasonable times and places the Company may designate, and shall cooperate with the Company in all matters pertaining to the loss.

11.5.3 In the case the Insured Person or Beneficiary and the Company shall fail to agree as to the amount of loss, it shall be determined by competent and disinterested appraisers, one to be selected by the insured or Beneficiary and another by the Company; the two appraisers so chosen shall select a competent and disinterested umpire; the appraisers then shall estimate and appraise the loss, stating separately the sound values and damage; should they fail to agree, they shall submit their differences to the umpire; an agreement and award in writing of any two shall determine the amount of the loss. The Insured Person or Beneficiary and the Company shall pay the fees and expenses of the appraisers respectively selected by them, and shall bear equally the fees and expenses arising from the appraisal proceedings.

11.5.4 In case of loss, it shall not only be lawful but also necessary for the Insured Person or Beneficiary, or the Insured Person's or Beneficiary's representatives, to sue, labor, and travel for the defense, safeguard and recovery of the property insured, without prejudice to this insurance. The Company will contribute to the expenses for

such efforts in the proportion which the Limit of Liability applicable in the policy bears to the total value of the property.

11.5.5 Each claim for loss shall be adjusted separately and from the amount of each loss, when determined, the deductible amount stated in the policy schedule shall be subtracted. All adjusted claims shall be paid or made good to Beneficiary as soon as practicable after the presentation and acceptance of satisfactory proof of interest and loss to the Company at the address shown above. No loss shall be paid hereunder if the Insured Person or Beneficiary has collected the same from others.

11.5.6 This insurance shall not accrue directly or indirectly to the benefit of any carrier or bailee.

11.5.7 If a loss covered by this policy is also covered by other insurance, the Company will pay only the proportion of the loss that the limit of liability that applies under the policy bears to the total amount of insurance covering the loss.

11.5.8 The Company cannot be brought to trial unless the Insured Person or Beneficiary complied with all provisions of the policy. The proceeding should be instituted within the prescriptive period settled by the legislation of the local law or within one year from the date of loss if other legislation is applicable to the policy.

12. ARTICLE 12 – LEISURE TRAVEL

The optional Leisure Travel insurance can only be taken insofar as the Insured Persons are covered by the Core Plan and only on a family level, i.e. for the Expatriated Employee and his Dependants together.

This benefit covers the Insured Person during Leisure Travel within the Benefit Period and within the limitations described in this policy, as well as during the journey to and from the destination.

The cover provided under this article for an Insured Person shall always end on the 91st day of a consecutive period of travel and/or stay outside the Host Country, unless this period is exceeded due to an unforeseen delay outside the control of the Insured Person. In that case, cover shall continue to be provided until the earliest possible date of return.

The benefits, insured under the core plan, also apply during Leisure Travel:

- Medical Expense Benefit
- Medical Service Provider Referral
- Telephone Medical Advice
- Second Medical Opinion Benefit
- Country Guides
- Assistance Benefit (Monitoring of Medical Condition, Emergency Medical Evacuation, Compassionate Visit, Return of Minor Child, Delivery of Essential Medication, Repatriation of the Body, Interpreter Referral and Legal Referral).
- Third Party Liability Benefit
- Legal Assistance.

12.1 Definitions

Business Equipment means goods that belong to the Policyholder and that the Insured Person carried or acquired during the Leisure Travel.

Cash and Valuable Documents means coins, banknotes, physical securities, bank drafts, funds, letters of credit, meal vouchers, bank cards, telephone cards, postal orders or cheques, traveler's cheques, tickets, fuel or other vouchers

with a monetary value or credit vouchers that are in the possession of, managed or supervised by the Insured Person and that are intended only for travel, meals, accommodation and personal expenditure.

Leisure Travel means any trip that is not related to work, which takes place during the Benefit Period and that last no longer than 90 consecutive days.

Personal Belongings means the objects and travel documents that the Insured Person has taken with him on a trip for personal use, as well as objects purchased during the trip, with the exception of business equipment.

12.2 Travel Assistance

Assistance Centre shall use its best endeavours to provide assistance services but any help and intervention depends upon, and is subject to local availability and has to remain within the scope of national and international law and regulations and intervention depends on Assistance Centre obtaining the necessary authorizations issued by the various authorities concerned.

Assistance Centre shall not be required to provide assistance services to the Insured Person, who is located in areas which represent war risks, political or other conditions that make assistance services impossible or reasonably impracticable.

12.2.1 Assistance Procedure

As described in article 5.1. above.

12.2.2 Cover

Medical Repatriation: If the Insured Person falls Ill or sustains Injury during a Leisure Travel, the Assistance Centre shall organize and pay for repatriation to the Host or Home Country of the Insured Person where appropriate as soon as he is fit to travel. The decision to repatriate as well as the choice of the most appropriate means of transport is made by the Medical Consultants of the Assistance Centre, if necessary in consultation with the local Physician in attendance.

Accommodation expenses: If the Insured Person falls Ill or sustains Injury during a Leisure Travel, and the Insured Person cannot be repatriated, his condition does not justify a further Hospital stay and his stay outside his Host Country has ended, the Company shall pay additional accommodation expenses until the earliest possible date of return.

Search and Rescue: If the Insured Person falls Ill or sustains Injury during a Leisure Travel, the Company shall pay up to a maximum of EUR 15,000 for the cost of search and rescue as a result of the Accident or the Illness, up to a maximum of 365 days from the day of the Accident or first diagnosis of the Illness.

Emergency return: the Assistance Centre shall organize and pay for the return of the Insured Person in the event of mortal danger or death of a relative in the first or second degree of the Insured Person or his partner, or in case of considerable material damage to the house where the Insured Person resides in the Host Country, while the said Insured Person is on a Leisure Travel. The travelling costs incurred by the Insured Person to return to the destination are reimbursed if this takes place within the originally scheduled travel period.

Travel Advice: At the request of the Insured Person, the Assistance Centre shall provide useful and relevant information in preparation of a Leisure Travel, including bank and currency regulations, information about obtaining a visa, health regulations and reciprocal agreements.

Message Relay: At the request of the Insured Person and in an emergency, the Assistance Centre shall relay messages to relatives and business partners. Colonnade Atlasz Assistance shall pay for the dispatching costs.

Lost Documents: At the request of the Insured Person and in an emergency, the Assistance Centre shall provide assistance in obtaining replacements for lost or stolen tickets, passports or travel documents.

Lost Luggage: At the request of the Insured Person and in an emergency, the Assistance Centre shall provide assistance in tracing lost luggage.

12.2.3 Limitations & Exclusions

The benefit in case of flights is limited to public transport in economy class, unless the Medical Consultants of the Assistance Centre decide otherwise.

The Company shall not pay any benefit:

- **For services that were not organized or approved in advance by the Assistance Centre.**
- **If the purpose of the trip is to obtain medical treatment or medical advice, unless in the course of an approved Emergency Medical Evacuation.**
- **If the Insured Person is traveling against the advice of a Physician.**
- **For services that are excluded in the Medical Expense cover or have their Date of Service during a waiting period mentioned under the Medical Expense cover.**

12.3 Personal Belongings and Business Equipment

12.3.1 Theft and Damage:

The Company shall pay the replacement value in the event of theft, total damage, or permanent loss by an airline company, or the repair costs in the event of partial damage, of the Personal Belongings and the Business Equipment of the Insured Person during a Leisure Travel, up to a maximum of EUR 7,500, or the sum insured stated in the policy schedule if different.

The replacement value is 75% of the purchase price during the first year after the purchase. The replacement value will be further reduced by 10% of the purchase price per year as from the second year, but will not be less than 25% of the purchase value.

12.3.2 Personal Baggage Delay:

The Company shall pay the additional expenditure up to EUR 1,500 that the Insured Person is forced to make during a Leisure Travel as a result of the delayed arrival of his Personal Belongings on the outward journey of a Leisure Travel.

Such additional costs are taken to mean expenditure for essential and reasonable replacement of critical items such as toiletries and clothing.

Delayed arrival of baggage means that on the outward journey or an intermediate flight, the Personal Belongings have not arrived within four hours of the Insured Person having arrived at the airport of destination. Only delays of scheduled flights operated by recognized airline companies are considered.

In the event of permanent loss, payment made for delay is deducted from the amount of any total claim compensation.

12.3.3 Loss or Damage of Travel Documents:

If during a Leisure Travel the passport, visa, money, tickets or other essential travel documents of the Insured Person are lost, damaged or stolen, the Company shall pay any reasonable and essential extra travelling and accommodation costs that the Insured Person incurs to replace such documents up to a maximum of EUR 2,500 per Insured Person.

12.3.4 Cash and Valuable Documents:

The Company shall compensate any damage due to theft of Cash and Valuable Documents, or as a result of the fraudulent use of bank cards, during a Leisure Travel up to a maximum of EUR 2,500 per Insured Person.

Currency and traveler's cheques purchased for a Leisure Travel are covered from the moment they are collected but not longer than 120 hours before the start of the Leisure Travel and up to the moment they are used or cashed in and not longer than 120 hours after the Insured Person has returned from the Leisure Travel.

12.3.5 Limitations & Exclusions

For any object with a value of over EUR 2,000, the first 25% of any sum higher than EUR 2,000 is excluded from the cover. This 25% is applied to the replacement value of the object or to the sum insured if this is lower.

The Insured Person must request a PIR report in case of a loss by an airline company.

The Insured Person must file a complaint at the local policy office in case of a theft.

The Company shall not pay any benefit if related to:

- **An object that has been lost, other than mentioned under the topics "permanent loss by an airline company", "Personal Baggage Delay" and "Loss or Damage of Travel Documents".**
- **The first 25% of the replacement value of Business Equipment.**
- **Loss or damage:**
  - **of glass, china or other fragile objects, unless caused by fire in, theft of or an accident with a means of transport in which these objects were being transported.**
  - **caused by moths, vermin, wear and tear, atmospheric or climatic conditions, scratches or scrapes.**
  - **caused by mechanical or electronic failure or defect.**
  - **caused by cleaning, painting, restoration, repair or changes made by the Insured Person.**
  - **caused by delay, seizure or confiscation by an authority.**
  - **to vehicles, accessories or parts thereof.**
  - **of personal property that is carried as freight on the basis of a transportation document.**
- **Loss or theft of a debit or credit card, which resulted in fraudulent use; unless the Policyholder or an Insured Person fulfilled all the conditions under which the card was issued.**

12.4 Cancellation, Interruption, Delay and Replacement

12.4.1 Cancellation and interruption

The Company shall pay up to EUR 10,000, or the sum insured stated in the policy schedule if different, if during the Benefit Period a Leisure Travel has to be cancelled, interrupted or changed as a direct result of an unforeseeable cause outside the control of the Insured Person.

If the Leisure Travel has to be cancelled before departure, the Company shall pay the travelling and accommodation costs that have been paid or have to be paid, insofar as these cannot be recovered from any other party.
If the Leisure Travel has to be interrupted after departure, the Company shall pay all the travelling or accommodation costs that have been paid or have to be paid and that are related to the period after such interruption, insofar as these cannot be recovered from any other party.

If pre-booked Leisure Travel arrangements have to be changed after departure, the Company shall pay the associated extra travelling and accommodation costs, insofar as these cannot be recovered from any other party, and which are necessary to enable the Insured Person to continue the Leisure Travel or to return to his Host Country.

12.4.2 Delay

If the departure of the aircraft, vessel or train on which the Insured Person is travelling on the outward or return journey of a Leisure Travel, is delayed as a direct result of a strike, industrial action, adverse weather condition or mechanical breakdown of the means of transport, the Company shall pay EUR 75 per Insured Person for each hour of delay after a delay of 4 hours, with a maximum of EUR 450 per Insured Person.

12.4.3 Exclusions

The Company shall not pay any benefit if related to:

- **A decision of the Insured Person, if this is not due to an unforeseeable cause outside the control of the Insured Person.**
- **Dismissal or termination of the contract of employment or expatriate assignment of the Insured Person within 31 days prior to a scheduled Leisure Travel or during the Leisure Travel.**
- **The financial circumstances affecting the Policyholder or an Insured Person.**
- **Non-performance of contract by a provider (or their agent) of transport or accommodation services.**
- **Regulations of a government institution.**
- **Strike, work stoppage, work-to-rule, mechanical breakdown or failure of any means of transport, except if the departure of a vessel, aircraft or train with which the Insured Person was scheduled to travel is delayed by at least 4 hours, unless the cause of the delay had already been announced before the Leisure Travel was booked.**
- **If the Insured Person is traveling against the advice of a Physician.**
- **If the purpose of the trip is to obtain medical treatment or medical advice.**
- **Failure of the Insured Person to check in according to the travel schedule, unless checking in was not possible due to a strike or a labor dispute.**
- **A transport ban, flying ban or driving ban that has been imposed by a port authority, an aviation authority, a rail authority or another government institution.**
- **The use or possession of narcotics not having been prescribed by a Physician**
- **Pregnancy or childbirth within one calendar month of the expected date of delivery.**

Unless otherwise agreed in writing, the Company shall not pay more than EUR 25,000 for all Insured Persons together in any Policy Period.