SPLOŠNI POGOJI ZA ZDRAVSTVENO ZAVAROVANJE NA POTOVANJIH V TUJINI Z ASISTENCO

PG-zdr-pt/06-11

triglav

1. člen: SPLOŠNE DOLOČBE

(1) Splošni pogoji za zdravstveno zavarovanje na potovanjih v tujini (v nadaljnjem besedilu splošni pogoji) so sestavni del zavarovalne pogodbe, sklenjene med zavarovalcem in Zavarovalnico Triglav, d.d., Ljubljana (v nadaljnjem besedilu zavarovalnica).
(2) Oseba, ki z zavarovalnico sklene pogodbo o zdravstvenem zavarovanju na potovanjih v tujini, se imenuje zavarovalec; oseba, od katere zdravljenja je odvisno izplačilo zavarovalnine in v korist katere se sklene zavarovanje, se imenuje zavarovanec.
(3) S pogodbo o zdravstvenem zavarovanju na potovanjih v tujini se zavarovalec obveže, da bo zavarovalnici plačal določena denarna sredstva (premijo), zavarovalnica pa se obvezuje, da bo ob nastopu zavarovalnega primera zavarovancu povrnila dokazane stroške potrebne zdravniške oskrbe ter stroške prevoza, vendar največ do višine zavarovalne vsote.

2. člen: PREDMET IN OBSEG ZAVAROVANJA

(1) Zavarovalno kritje obsega stroške potrebne zdravniške oskrbe ter stroške prevoza zaradi nepredvidenih bolezni ali posledic nesreče oz. nezgode, ki se pojavijo ali nastanejo med potovanjem ali bivanjem v tujini.
(2) Zavarovalni primer se začne z začetkom zdravljenja in konča takrat, ko po mnenju lečečega zdravnika zdravljenje ni več potrebno.
(3) Če se zdravljenje nanaša na bolezen ali posledice nezgode, ki s prejšnjimi niso v vzročni zvezi, zavarovalnica šteje to kot nov zavarovalni primer.

3. člen: SKLENITEV ZAVAROVANJA

(1) Zavarovanje je potrebno skleniti pred pričetkom potovanja. Zavarovanje, sklenjeno po pričetku potovanja, ni veljavno.
(2) Zavarovanje je sklenjeno, ko zavarovalnica ali njena pooblaščena oseba izda potrjeno zavarovalno polico. Zavarovalnica lahko pri pogodbah, sklenjenih na daljavo, določi, da je zavarovanje sklenjeno s samim plačilom premije.
(3) Zavarovalec ima pravico, da v primeru, ko gre za pogodbo na daljavo, v roku 15 dni od dneva sklenitve zavarovanja odstopi od zavarovalne pogodbe. Odstop mora biti pisen in vložen na zavarovalnico do izteka roka, pri čemer se šteje, da je vložen v roku, če je do izteka roka priporočeno oddan na pošti. Zavarovalnica je v tem primeru upravičena obdržati zavarovalno premijo (stroške) za vsak dan zavarovalnega kritja. Zavarovalec nima pravice do odstopa od pogodbe pri zavarovalnih pogodbah z veljavnostjo, krajšo od enega meseca.

4. člen: ZAČETEK IN TRAJANJE ZAVAROVALNEGA KRITJA

(1) Zavarovalno kritje se začne ob 00.00 tistega dne, ki je v zavarovalni polici naveden kot dan začetka zavarovanja, če je do takrat plačana zavarovalna premija. Če zavarovalna premija do tedaj ni plačana, se začne zavarovalno kritje ob 00.00 naslednjega dne, ko je plačana.
(2) Zavarovalno kritje preneha ob 24.00 tistega dne, ki je v polici naveden kot dan prenehanja zavarovanja.
(3) Zavarovalno kritje v nobenem primeru ne velja v Republiki Sloveniji.

5. člen: PLAČILO ZAVAROVALNE PREMIJE

(1) Zavarovalec je dolžan plačati zavarovalno premijo takoj ob prejemu zavarovalne police.
(2) Za preračun zavarovalne premije v uradno denarno enoto Republike Slovenije se upošteva srednji tečaj Banke Slovenije na dan plačila premije.
(3) Če se nakazuje premija po pošti ali banki, velja, da je zavarovalnici plačana ob 24.00 tistega dne, ko je plačilo potrjeno na pošti ali banki.

6. člen: OBVEZNOSTI ZAVAROVALNICE

(1) Zavarovalnica povrne - razen v primerih, navedenih v 7. členu teh pogojev - stroške potrebne zdravniške oskrbe in stroške prevoza, ki so nastali zavarovancu v času potovanja v tujini.
(2) Za stroške potrebne zdravniške oskrbe v smislu teh pogojev veljajo izključno stroški:
   a) zdravniške oskrbe;
   b) zdravil in povojev, če jih predpiše zdravnik;
   c) pripomočkov, ki so potrebni za zdravljenje (npr. mavec, opornice, obveze in bergle), če jih predpiše zdravnik;
   d) zdravniško predpisanih toplotnih terapij, obsevanj in ostalih fizikalnih terapij;
   e) rentgenske diagnostike;
   f) oskrbe v ambulanti, ki razpolaga z zadostnimi diagnostičnimi in terapevtskimi zmogljivostmi in dela po metodah, ki so v državi začasnega bivanja znanstveno priznane in klinično preizkušene. Zavarovanec se mora obrniti na bolnišnico v kraju začasnega bivanja oziroma v najbližjo primerno bolnišnico;
   g) prevoza do bolnišnice;
   h) operacije (vključno z odvisnimi stroški operacije);
   i) nujnih zobozdravstvenih posegov, potrebnih za odpravo akutne bolečine zaradi bolezni ali poškodbe zobovja, vključno ekstrakcijo zoba, kakor tudi enostavnih popravil zobnih protez, ne pa izdelave nadomestnih zob ali zobnih kron.
(3) Za **stroške prevoza** v smislu teh pogojev veljajo izključno:
   a) povečani stroški prevoza zavarovanca v domovino, ki ga odredi zdravnik, če v obiskanem kraju ali v bližnji okolici ni mogoče nuditi zadostne medicinske oskrbe in to lahko vpliva na poslabšanje bolnikovega zdravja. Poleg tega se povrnejo tudi dodatni povečani stroški za spremljevalca, če je zdravniško spremstvo potrebno ali predpisano z zakonom;
   b) v primeru smrti - potrebni povečani stroški prevoza v domači kraj, ali nujni povečani stroški, ki so posledica pokopa v tujini, vendar največ do zneska, dogovorjenega v zavarovalni polici.

   Povečani stroški v smislu zgornjih določil so:
   - v primeru prevoza bolnika v domovino tisti, ki so dodatno nastali zaradi nastopa zavarovalnega primera ob vrnitvi domov;
   - v primeru smrti tisti, ki presegajo stroške, ki bi nastali ob smrti zavarovanca doma.
(4) Maksimalno jamstvo zavarovalnice na posameznem potovanju je določeno z zavarovalno vsoto na polici.

7. člen: IZKLJUČITVE IZ ZAVAROVALNEGA KRITJA

Zavarovalnica ne krije stroškov **zdravniške oskrbe in stroškov prevoza** zaradi:
   a) kroničnih bolezni in posledic, ki so nastale in bile znane ob začetku avarovanja, tudi če niso bile zdravljene, kakor tudi bolezni, zdravljenih v zadnjih 3 mesecih pred začetkom zavarovanja, vključno z njihovimi posledicami, razen če gre za nepredvideno zdravniško pomoč za odpravljanje akutne življenjske nevarnosti ali za ukrepe, katerih namen je izključno odpravljanje akutnih bolečin. Iste izključitve veljajo za posledice nesreče;
   b) bolezni in nezgod, ki jih utrpi zavarovanec kot posledico vojnih dogodkov in v aktivnem sodelovanju v neredih;
   c) bolezni in nezgod, ki jih utrpi zavarovanec v času aktivnega športnega tekmovanja ali priprav, ki jih organizirajo športne zveze ali društva, razen če je to izrecno dogovorjeno in je plačana ustrezna višja premija;
   d) bolezni in nezgod, ki jih zavarovanec utrpi pri kaznivih dejanjih ali jih namerno povzroči, ali pa če so posledica vinjenosti ali vpliva mamil;
   e) odstranitev lepotnih napak ali telesnih anomalij, preventivnih cepljenj, dezinfekcij, zdravniških izvidov in testiranj;
   f) stroškov, ki nastanejo v času bivanja v kopališčih, zdraviliščih, sanatorijih, okrevališčih, zdravstvenih zavodih in domovih ali podobnih ustanovah zaradi okrevanja;
   g) stroškov psihoanalitičnega ali psihoterapevtskega zdravljenja;
   h) stroškov, povezanih z nosečnostjo, porodom in njegovih posledic, razen pri akutnem, nenormalnem poteku nosečnosti in njegovih posledicah ko zavarovalnica krije stroške zdravniških ukrepov za neposredno odpravljanje življenjske nevarnosti za mater ali otroka, če nosečnica ob nastopu akutne komplikacije še ni izpolnila 36. leta življenja in če trideseti teden nosečnosti še ni zaključen;
   i) zdravniške pomoči pri težavah, ki so tipične za nosečnost in njene posledice, vključno s spremembo kroničnih težav, ki so posledica nosečnosti;
   j) nadzorovanja nosečnosti ali stroškov prekinitve nosečnosti;
   k) oskrbe, ki jo nudi zavarovančev partner, otroci ali starši, razen dokazanih materialnih stroškov;
   l) rehabilitacije in protez;
   m) oskrbe, ki ni navedena v 6. členu teh pogojev.

8. člen: DOLŽNOSTI ZAVAROVANCA OZIROMA ZAVAROVALCA

(1) Zahtevek iz zavarovanja je potrebno uveljavljati v treh mesecih po končanem zdravljenju oziroma prevozu v domovino ali smrtnem primeru.
(2) Zavarovalec in zavarovanci so zavarovalnici na njeno zahtevo dolžni dati vse podatke, ki so potrebni za ugotavljanje zavarovalnega primera ali pa za ugotavljanje obsega zavarovalnega kritja.
(3) Zavarovalec in zavarovanci pooblaščajo zavarovalnico za zbiranje vseh njej potrebnih podatkov pri tretjih osebah (zdravnikih, zobozdravnikih, zdravstvenih delavcih, zdravstvenih zavodih vseh vrst, zavodih zdravstvenega zavarovanja, uradih za zdravstvo ali za oskrbo).
(4) Zavarovalnica je prosta obveznosti, če zavarovalec ali zavarovanec kršita določila tega člena.

9. člen: IZPLAČILO ZAVAROVALNINE

(1) Zavarovalnica je dolžna izpolniti svojo obveznost le v primeru, če so bili poleg dokaza o zavarovalnem kritju predloženi zahtevani dokazi, navedeni v odstavkih od (2) do (5) tega člena.
(2) Zavarovalnici je treba izročiti izvirnike računov o nastalih stroških. Če izroči upravičenec do zavarovalnine duplikate računov, mora te overiti pri ustanovi, ki ima izvirnike.
(3) Na računih mora biti vpisano zavarovančevo ime, opis bolezni, navedbe posameznih zdravniških storitev s podatki o zdravljenju; iz računa za zdravilo mora biti jasno vidno predpisano zdravilo, cena in štampiljka lekarne. Pri oskrbi zob morajo imeti računi opis zdravljenih zob in zdravniških posegov, ki so bili na njih izvedeni.
(4) Zahtevek za izplačilo prevoznih ali pogrebnih stroškov je potrebno utemeljiti z računi, kot tudi z uradnim mrliškim listom in z zdravniškim potrdilom o vzroku smrti, zahtevek za povračilo stroškov prevoza bolnika v domovino pa s predložitvijo računov in zdravniškega potrdila z opisom bolezni. Zdravniško potrdilo mora poleg tega dokazovati medicinsko nujnost povratnega prevoza.
(5) Zavarovalnica izplača zavarovalnino zavarovancu, ki je imel zavarovalni primer. Če pa je katera od navedenih oseb zaradi posledic zavarovalnega primera umrla, izplača zavarovalnica zavarovalnino njegovim dedičem.
(6) Če je zavarovanec ob sklenitvi neresnično prijavil svojo starost, njegova resnična starost pa presega 65 let, se zavarovalnina zmanjša v sorazmerju med dogovorjeno premijo in premijo, ki bi morala biti plačana pri resnični zavarovančevi starosti.
(7) Zavarovalnina se obračuna in izplača v evrih, do uvedbe evra kot uradne denarne enote Republike Slovenije, pa se izplača v tolarski protivrednosti po srednjem tečaju Banke Slovenije, ki velja na dan izplačila.

10. člen: KONEC ZAVAROVALNEGA KRITJA

(1) Zavarovalno kritje preneha:
   - s potekom veljavnosti zavarovalne police ali
   - z vrnitvijo v domovino ali
   - s prevozom v smislu določila a) točke (3) odstavka 6. člena.
(2) Za konec bivanja v tujini velja prestop državne meje Republike Slovenije.
(3) Če se zdravljenje brez prekinitve nadaljuje tudi po preteku veljavnosti zavarovalne police, nudi zavarovalnica zavarovalno kritje tudi za stroške tega zdravljenja, toda največ za 4 tedne in s pogojem, da obolelega zavarovanca ni bilo mogoče prepeljati domov ali če se povratek zavleče zaradi vzrokov, na katere zavarovanec ni mogel vplivati.

11.člen: ODSTOP IN POBOT ZAHTEVKOV

(1) Če ima zavarovalec ali zavarovanec proti tretjim osebam odškodninske zahtevke, ki niso zavarovalnopravne narave, mora te zahtevke do višine izplačane zavarovalnine pisno odstopiti zavarovalnici.
(2) Če se zavarovalec ali zavarovanec odpove takšnemu zahtevku - ali pravici za zavarovanje zahtevka - brez privolitve zavarovalnice, izgubi pravico do ustreznega dela zavarovalnine.
(3) Če prejme zavarovalec ali zavarovanec nadomestilo od osebe, odgovorne za škodo, sme zavarovalnica od zavarovalnine odbiti znesek tega nadomestila.
(4) Terjatve proti zavarovalnici zavarovalec ali zavarovanec ne more niti zastaviti niti odstopiti.

12. člen: VARSTVO OSEBNIH PODATKOV

[1] Zavarovalec v skladu z Zakonom o varstvu osebnih podatkov dovoljuje, da se osebni podatki iz ponudbe ali pristopne izjave uporabljajo v zbirki podatkov, ki jo vzpostavi, vodi in vzdržuje zavarovalnica in z njo kapitalsko povezana ter pooblaščena podjetja za zastopanje in posredovanje zavarovanj.
[2] Navedeni osebni podatki se bodo uporabljali le v času trajanja zavarovanja in z namenom obveščanja zavarovalca o novostih in ponudbah zavarovalnice. Zavarovalnica se obvezuje, da bo zdravstvene podatke, kot tudi vse druge osebne podatke, skrbno varovala v skladu z veljavno zakonodajo.

13. člen: IZVENSODNO REŠEVANJE SPOROV

(1) Zoper odločitev zavarovalnice je dovoljena pritožba. Pritožba se vloži na tisto organizacijsko enoto Zavarovalnice Triglav, d.d., kjer je bilo sklenjeno zavarovanje. Pritožba se lahko odda osebno, po pošti ali na spletnih straneh www.zav-triglav.si.
(2) Pritožbo obravnava pristojna pritožbena komisija v skladu s pravilnikom, ki ureja interni pritožbeni postopek zavarovalnice. Odločitev pritožbene komisije je dokončna.
(3) V primeru nestrinjanja z odločitvijo pritožbene komisije se lahko po posebnem dogovoru nadaljuje postopek za izvensodno rešitev spora pri arbitraži zavarovalnice ali pri mediacijskem centru, ki deluje v okviru Slovenskega zavarovalnega združenja.

14. člen: ZAKLJUČNA DOLOČILA

Za odnose med zavarovalnico in zavarovalcem, ki niso urejeni s temi splošnimi pogoji, se uporabljajo zakonska določila, ki urejajo obligacijska razmerja.

Ti pogoji z oznako PG-zdr-pt/06-11 se uporabljajo od 1. novembra 2006

GENERAL CONDITIONS FOR TRAVEL HEALTH INSURANCE

PG-zdr-pt/06-11

triglav

Art. 1: GENERAL PROVISIONS

(1) General terms for health insurance during travelling abroad (hereinafter referred to as general conditions), are constituent part of the insurance contract made between the Policy holder and the Zavarovalnica Triglav , d.d., Ljubljana (Triglav Insurance Company Ltd, Ljubljana).

(2) The person who enters into a contract with the Insurance Company on health insurance covering a travelling abroad is called the Policy Holder, and the person of whose health treatment the payment of the sum insured depends and in whose favour the insurance has been concluded is called the Insured.

(3) By ent ering into the contract on life insurance covering the period when travelling abroad the Policy Holder covenants to pay to the Insurance Company the stipulated amount of money (Premium) whereas the Insurance Company undertakes to reimburse to the Insured the approved costs of medical treatment needed and transport costs, not exceeding the sum insured, should a case incidence covered by this insurance policy arise.

Art. 2: SUBJECT AND SCOPE OF INSURANCE

(1) The insurance cover comprises the costs of medical treatment needed and transport costs due to a disease unforeseen or consequences of misadventure or accident occurred or commenced during travelling or staying abroad.

(2) The case insured starts at commencement of the medical treatment and terminates when the treating physician declares further treatment not needed any longer.

(3) If the medical treatment is related to a disease or accident consequences that are not caused by previous diseases or accidents the Insurance Company regards this as a new case.

Art. 3: CONCLUSION OF INSURANCE AGREEMENT

(1) The Insurance must be concluded prior to the starting date of the journey. The insurance contract made after the journey has started is not valid.

(2) The insurance is concluded when the Insurance Company or its authorised representative issues a confirmed insurance policy. For insurance contracts concluded at a distance, the Insurance Company can determine insurance to be concluded when the premium is paid.

(3) With a distance contract, the Policyholder has the right to cancel the insurance contract within 15 days of the day of the conclusion of the contract . A notice of cancellation must be produced in writing and submitted to the Insurance Company before the expiry of the cancellation period; it is deemed submitted in due time if it is posted as a registered letter before the expiry of the aforementioned cancellation period. In such a case the Insurance Company is entitled to keep the insurance premium (costs) for each day of the insurance cover. The Policyholder has no right to cancel insurance contracts concluded for a period shorter than one month.

Art. 4: START AND DURATION OF THE INSURANCE COVER

(1) The insurance cover starts at 00:00 hours of the day stated in the insurance policy, as the insurance commencement day, provided the insurance premium has been paid by then. If the insurance premium is not paid by then the insurance cover starts at 00:00 hours of the day following the payment.

(2) The insurance cover ceases at 24:00 hours of the day stated as the termination day in the insurance policy.

(3) The insurance cover shall under no circumstances apply in the Republic of Slovenia.

Art. 5 - PAYMEN T OF THE INSURANCE PREMIUM

(1) The policy holder is obliged to pay the insurance premium immediately after receipt of the insurance policy.

(2) The premium is converted into the legal tender of the Republic of Slovenia at the mean exchange rate of the Bank of Slovenia as on the day of paying the premium.

(3) If the premium is remitted through post office or a bank it is agreed that it is paid to the Insurance Company at 24:00 hours of the day when the remittance has been confirmed by the post office or by the bank.

Art. 6 - OBLIGATIONS OF THE INSURANCE COMPANY

(1) The Insurance Company indemnifies - except in cases as stated in Art. 7 of these conditions - for the costs of the medical treatment needed and transport costs sustained by the Insured during the journey abroad.

(2) As costs of the medical treatment needed according to these conditions apply exclusively the costs of:

a) medical treatment;
b) medicines and bandages subscribed by the doctor;
c) medical aids for cure needed (for example plaster, supporters, bandages, crutches) if subscribed by the doctor;
d) thermal therapies, radiation and other physical therapies if subscribed by the doctor;
e) X - ray diagnostics;
f) clinical services if the dispensary disposes with sufficient diagnostic and therapeutic facilities and operates according to methods scientifically acknowledged and clinically tested in the country of temporary stay. The Insured must refer to the hospital in the place of his temporary stay or to the closest hospital as appropriate;
g) transport to hospital;
h) operations (including indirect costs of operation);
i) urgent dental interventions needed for healing acute pain due to dental disease or damage of teeth including tooth extraction and simple repair of teeth prosthesis excluding finishing of spare teeth or tooth crowns.

(3) As transport costs according to these conditions apply exclusively:

a) increased transport costs of the Insured to the homeland when transport ordered by the doctor in case there is no possibility of sufficient medical care in the place visited or in the close neighbourhood, and this could affect and worsen the patient's health. Apart from that, also additional increased cost for the companion shall be refunded if the medical escort is needed or prescribed by Law;
b) in case of death - increased transport costs needed to the home place or urgent increased costs of burial in the foreign country, however not exceeding the sum as stipulated in the insurance policy.

The increased costs according to the provisions as above are:

- in case of transport of the patient into his homeland, the costs that followed additionally because of occurrence of the case insured at returning home;
- in the event of death, the costs exceeding the costs that would incur due to the Insured's death at home;

(4) The maximum liability of the Insurance Company per individual trip/journey is determined by the sum insured in the insurance policy.

Art. 7: EXCLUSIONS FROM THE INSURANCE COVER

The Insurance Company does not cover the costs of medical treatment and transport costs due to:

a) chronic disease and consequences that started and were known at commencement of the insurance cover although not treated, as well as the diseases medicated during the last 3 months prior to commencement of the insurance cover including their consequences, except in case of an unforeseen medical assistance to prevent an acute vital danger or exclusively, in case of measures for fighting acute pains. The same exclusions apply for accident consequences;
b) diseases and accidents sustained by the Insured as result of war events and in active participation in riots;
c) diseases and accidents sustained by the Insured during the period of active sport competitions or preparations organised by sport associations or clubs except it has been explicitly agreed upon and a proportionally higher premium has been paid;
d) diseases and accidents sustained by the Insured when committing a criminal offence, or if deliberately caused by him or if they are a result of drunkenness or drug affection;
e) removal of aesthetic defects and bodily anomalies, preventive vaccinations, disinfecting, medical diagnosis, and tests;
f) costs incurred during the stay in spas, health resorts, sanatoriums, rehabilitation centres, health institutions and homes or similar institutions for the sake of health rehabilitation;
g) costs of psychoanalytical or psychotherapeutical treatment;
h) costs in connection with pregnancy, birth and its consequences except in acute, abnormal course of pregnancy and its consequences when the Insurance Company covers the costs of medical measures for direct elimination of danger for life of mother or child if the pregnant woman has not completed 36 years of age at the start of the acute complication, and if the 30th week of pregnancy has not been completed yet;
i) medical assistance in troubles typical for the pregnancy and its consequences including the change of chronic troubles as a result of pregnancy;
j) pregnancy monitoring or abortion costs;
k) care rendered by the Insured's partner, children or parents, except the costs of material as approved;
l) rehabilitation and prosthesis;
m) care not defined in Art. 6 of these conditions.

Art. 8: THE INSURED OR THE POLICY HOLDER LIABILITIES

(1) Liability claim arising from the insurance case occurrence must be put forward within three months following the terminated medical treatment or transport to the homeland respectively or in the event of death;

(2) The policy holder and the Insureds are obliged to give to the Insurance Company at its request all the information needed for the insurance case assessment or for determination of the insurance cover scope.

(3) The policy holder and the Insureds authorise the Insurance Company for gathering all information needed by it from third persons (doctors, dentists, medical workers, medical institutions of all sorts, institutions of health insurance, health or care administrations).

(4) The insurance Company is free not to fulfil its obligation if the policy holder or the Insured break the provisions of this article.

Art. 9: PAYMENT OF THE SUM INSURED

(1) The Insurance Company is obliged to fulfil its obligation only provided besides the evidence of the insurance cover also the requested evidence as stated in paragraphs from (2) to (5) of this Article have been presented.

(2) The original invoices/bills with respect to the costs incurred must be presented to the Insurance Company. If the entitled person to collect the sum insured presents duplicates of bills the same must be certified by the institution being in possession of the originals.

(3) The bills must comprise the Insured's name, description of the disease, list of individual medical services with treatment details. The bill for the medicine must clearly state the title of the medicine prescribed, its price and stamp of the pharmacy store. In dental treatment, the bills must comprise a description of the teeth treated and dentist's operations made on them.

(4) The claim for payment of transport or funeral costs must be supported by bills and an official death certificate and medical certificate/report on the cause of death, whereas the claim for refund of the patient's transport to the homeland must base on presentation of the bills and medical certificate with a description of the disease. Besides that, the medical certificate must prove the medical necessity of the return transport.

(5) The Insurance Company shall pay the insured sum to the Insured related to the case insured occurred to him. In the event of death of any of the persons stated theInsurance Company shall pay the sum insured to his heirs.

(6) If, whil e concluding the Insurance Contract, the Insured gave a false information about his age, and his real age is over 65 years, the sum insured shall be diminished in proportion to the premium agreed and the premium to be paid if the real age of the Insured has been stated.

(7) The benefit is accounted and paid out in euros, whilst before the introduction of the euro as the legal tender in the Republic of Slovenia it is paid out in the equivalent in Slovenian tolars calculated at the mean exchange rate of the Bank of Slovenia as on the day of paying the benefit.

Art. 10: TERMINATION OF INSURANCE COVER

(1) The insurance cover terminates:

- at expiration of the insurance policy validity or
- at return to the homeland or
- at transport according to provision of point a) paragraph (3)of Art. 6.

(2) Crossing of the border of the Republic of Slovenia stands for the termination of stay abroad.

(3) Should the medical treatment continue without interruptions even after expiration of the insurance policy validity the Insurance Company shall offer the insurance cover covering also the costs of this treatment not longer than 4 weeks at the most and under the condition that the sick person insured could not be transported home or the return trip was postponed due to the reasons beyond the power of influence of the Insured.

Art. 11: ASSIGNMENT AND COMPENSATION OF CLAIMS

(1) Should the policy holder or the insurer assert indemnity claims to third persons that are not subject to the insurance contract he must assign these claims in writing to the Insurance Company in the amount of the sum insured paid.

(2) Should the policy holder or the Insured waive such a claim - or his right of claim assurance - without the Insurance Company's consent, he loses the right of claiming the proportional part of the sum insured.

(3) Should the policy holder or the Insured be indemnified by the person responsible for the damage, the Insurance Company is entitled to deduct the sum of this indemnity from the sum insured.

(4) The policy holder or the Insured may neither pawn nor assign his claims to the Insurance Company.

Art. 12: PROTECTION OF PERSONAL DATA

(1) In line with the Personal Data Protection Act, the Policyholder authorises the use of personal data from the Application and the Enrolment Form in the database that is established, administered and maintained by the Insurance Company and its associated companies and companies authorised by it for agency and brokerage services.

(2) Such personal data will only be used during the term of insurance for the purpose of informing the Policyholder about the Insurance Company's new offers. The Insurance Company undertakes to protect all medical and other personal data with due diligence and in compliance with the existing legislation.

Art. 13: OUT-OF-COURT SETTLEMENT OF DISPUTES

(1) An appeal is permissible against decisions made by the Insurance Company. An appeal should be lodged at the branch of the Insurance Company where the insurance was concluded either personally, by post or at the website www.zav-triglav.si.

(2) Appeals are handled by the competent appellate commission in line with the Rules governing the internal appellate procedure in the Insurance Company. The decision of the appellate commission is final.

(3) If the parties disagree with the decision of the appellate commission, the procedure of out-of-court settlement can continue by special agreement at the Arbitration Board of the Insurance Company or at the Mediation Centre within the Slovenian Insurance Association.

Art. 14: FINAL PROVISIONS

Any other relations between the Insurance Company and the Policyholder that are not specifically mentioned in these General Terms and Conditions are governed by the provisions of the existing contract law.