

Medical Travel Insurance Legal Terms

Contractual clauses attached to the health insurance policy for travel abroad

C.A. „GENERAL ASIGURĂRI” S.A., IDNO: 1016600035165, MD-2005, or. Chişinău, str. Puşkin, nr. 47/5, tel./fax: (+373) 22 783 800/801, hereinafter referred to as the "Insurer", represented by the General Director acting under the Articles of Association or by a representative of the Insurer, and the Policyholder named in the insurance policy, have agreed as follows:

I. General provisions

This contract is based on the Voluntary Health Insurance Conditions for Travel Abroad (hereinafter the Conditions), drawn up in accordance with the Civil Code of the Republic of Moldova, Law of the Republic of Moldova No. 92 of 07.04.2022 on insurance or reinsurance activity, and other regulations in force, and is classified as "General Insurance", class 2, "Health Insurance".

The insurance conditions form an integral part of the Voluntary Health Insurance Contract for Travel Abroad. This Insurance Contract may also stipulate other contractual conditions, established by mutual agreement of the parties, provided they do not contravene the regulations in force.

The Insurer does not provide insurance cover for persons who, at the time the Contract is concluded:

- are outside the Republic of Moldova at the time the Contract is concluded;
- are undergoing outpatient/inpatient treatment;
- are registered with narcological, psychoneurological, phthisiological, or dermatovenereological dispensaries.

II. Terms used and their meaning

For the purpose of determining and regulating the contractual relations under these contractual conditions, and establishing the rights and obligations of the Contracting parties, the following terms are used:

2.1. Insurer — C.A. „GENERAL ASIGURĂRI” S.A., which holds the right to carry out insurance activity under licence, according to which, in exchange for the insurance premium collected, it undertakes to cover through insurance the risks stipulated in these Conditions.

2.2. Insured (insured person) — a natural person, in whose favour the Voluntary Health Insurance Contract has been concluded with the Insurer, and for whom the object of insurance, under the concluded Contract, is their life, health and working capacity.

2.3. Policyholder — the natural or legal person who has concluded the insurance contract with the Insurer and has undertaken to pay the insurance premium. The Policyholder may simultaneously also be the Insured, where the object of insurance under the concluded Contract is their own life and health. In the case of family insurance, the Policyholder may be either spouse. In the case of collective insurance, the Policyholder may be the Employer/Trip Organiser or, in the case of participatory cooperation, an employee of the company/group leader. Only persons entered on the "List of persons subject to voluntary medical assistance insurance under the Collective Contract" qualify as Insured persons (beneficiaries of the insurance).

2.4. Sudden illness — an organic or functional change in the Insured's normal state of health, diagnosed as such by a specialist doctor, contracted during the period of validity of the insurance or manifesting for the first time during the period of validity of the insurance, and requiring emergency medical treatment to avoid death or serious deterioration of the Insured Person's health. In establishing the existence of such a condition, the Assistance Company's doctor may take into account the geographic location of the Insured Person, the nature of the medical emergency, and the availability of suitable medical services or resources in the relevant location.

2.5. Pre-existing condition (chronic illness) — any illness, injury resulting from an accident, or other medical condition of the Insured, diagnosed as such by a doctor, present before the Insured's entry into insurance, with the exception of acute conditions that have been fully cured, and referring to: any respiratory illness (affecting the lungs and breathing), heart disease, stroke, or cancer for which the Insured Person has ever received treatment (including surgery, tests or investigations performed by the Insured Person's doctor or a consultant/specialist, as well as prescribed medication); any condition for which the Insured Person has undergone surgery, inpatient treatment, or investigations in a hospital or clinic during the last six months.

2.6. Accident — a sudden (accidental) event caused by a mechanical or chemical factor originating externally and beyond the Insured's will, which results in bodily injury detectable from a medical point of view, permanent disability, or the Insured's death. For the purposes of this definition, in order to delimit the risk arising while driving a motor vehicle, a "accident" is also deemed to include the collision of two or more motor vehicles occurring on public roads, or their collision with another obstacle, overturning, skidding, or fire, resulting in bodily injury or the death of the Insured.

2.7. Insured case — the insured risk, provided for in the voluntary health insurance contract for travel abroad, the occurrence of which gives rise to the Insurer's liability towards the Insured.

2.8. Insured event — a disruption of the Insured's health as a result of an accident, sudden or acute illness, or the aggravation of chronic diseases during the valid insurance period — conditions posing a danger to life and/or requiring emergency medical intervention; conditions or states, or other occurrences requiring medical care.

2.9. Main insured risks — an event or group of possible but uncertain future phenomena or events, referred to in the Voluntary Health Insurance Contract for Travel Abroad, stipulated in the Insurance Package, the occurrence of which may cause harm to the insured person. On the basis of these Conditions, the Insurer guarantees the provision of medical assistance through the Assistance Company, in accordance with the Voluntary Health Insurance Contract for Travel Abroad, to the extent provided for by the Insurance Package, and pays financial compensation, in kind or mixed, where the beneficiary of the insurance has incurred costs for the medical treatment administered as a result of a disruption to their health.

2.10. Assistance Company — the Insurer's partner/representative, which has established a contractual cooperation relationship in the field of servicing Insured persons at the time an insured case occurs and/or in settling claims for compensation with medical service providers.

2.11. Insurance Contract — the freely agreed arrangement concluded between the Insurer and the Policyholder (Insured) by which legal relationships are established, amended or terminated. The Insurance Contract is concluded in writing, on the basis of the completed Insurance Application, and stipulates the rights, obligations and the mechanism for their fulfilment. Under the insurance contract, the Policyholder undertakes to pay the Insurer the insurance premium, and the Insurer undertakes to pay the Insured the insurance indemnity upon the occurrence of the insured case within the insurance period. The Insurance Contract consists of the insurance application, the Insurance Policy issued by the insurer, and the contractual clauses attached to the voluntary health insurance policy for travel abroad.

2.12. Insurance Policy — the document confirming the conclusion of the voluntary health insurance contract for travel abroad.

2.13. Insurance premium — the amount which the Insured (Policyholder) is required to pay to the Insurer upon delivery of the insurance policy, in the manner and within the term provided for by the insurance contract, in exchange for the Insurer's assumption of the insured risk.

2.14. Sum insured — the maximum limit of the Insurer's liability in the event of the occurrence of the events for which the insurance contract was concluded. The value of the sum insured depends on the Insurance Package requested and the insured Territory.

2.15. Recreational Sports and/or Professional Sports and/or Work (performed abroad) option — the increased contractual premium above the standard tariff, which the Policyholder must pay in exchange for

insurance against the risks referred to in the contractual documents, arising from engaging in recreational sports and/or professional sports and/or a gainful activity involving physical labour, a professional activity with increased risk (construction, heavy industry, security work, etc.). Accordingly, the Insurer will not pay the insurance indemnity in the following situations:

- if the insured risk occurred as a result of an activity from among those listed above, if the "Recreational Sports" and/or "Professional Sports" and/or "Work" option was not selected;
- if the insured risk occurred as a result of engaging in dangerous sports or hobbies — extreme sports.

2.16. Recreational sports — skiing, water skiing, snowboarding, ice skating, surfing, horse riding, karting, mountain biking, rafting, etc., practised occasionally for recreational purposes. If, during the trip, the Insured intends to occasionally engage in sports activities for recreational purposes, it is recommended to select this additional cover when taking out the insurance policy.

2.17. Professional (competitive) sport — in accordance with the categories below:

- Group A – athletes, associations (teams) for bowling, fishing, golf, badminton, skittles, minigolf, competitive dance, shooting, swimming, entertainment;
- Group B – athletes, associations (teams) for athletics, basketball, ice skating, rowing, fencing, field hockey, canoeing, cycling, roller skating, tennis, table tennis, gymnastics, volleyball, water skiing;
- Group C – athletes, associations (teams) for heavy athletics, weightlifting, luge/bobsleigh, ice hockey, skiing;
- Group D – associations (teams) for equestrian sports, football, handball, polo, rugby, martial arts, sports tourism;

This list is illustrative and not exhaustive. If, during the trip, the Insured intends to engage in sporting activities — training camps, sports competitions of any level — it is recommended to select this additional cover when taking out the insurance policy.

2.18. Physical labour — a coefficient applied where the purpose of the Insured's trip abroad is to carry out a professional activity involving physical labour with increased risk, such as heavy industry, security work, or construction. This list is illustrative and not exhaustive.

III. Subject matter of the insurance

3.1. The subject matter of the voluntary health insurance for travel abroad (main risk) consists of the pecuniary interests, which do not contravene the legislation of the Republic of Moldova, relating to the Insured's person, life and health.

3.2. In accordance with the concluded Voluntary Health Insurance Contract for Travel Abroad, the Insurer provides insurance cover for main risks and/or ancillary risks, contracted and named in the Insurance Policy, during the valid period of the insurance cover, and pays compensation in accordance with these contractual clauses.

IV. Persons covered by the insurance

4.1. Natural persons, citizens of the Republic of Moldova, stateless persons, or foreign citizens may be covered by the voluntary health insurance for travel abroad.

4.2. In the case of insuring persons aged 0–12 months or persons over 65 years of age, or foreign citizens without residence in the Republic of Moldova, the Insurer is entitled to increase the cost of insurance in accordance with the results of the underwriter's assessment of the risks accepted for insurance.

V. Territorial coverage. Period of validity

5.1. The voluntary health insurance for travel abroad is valid outside the territory of the Republic of Moldova and the countries of residence of the Insured, on the territory indicated in the insurance policy, as follows:

TERRITORIAL COVERAGE	
Zone A	Former Soviet Union countries
Zone B	Turkey
Zone C	Europe, Turkey, former Soviet Union countries
Zone D	Asia, Europe, former Soviet Union countries
Zone E	Worldwide

5.2. The period of validity of the insurance may range from 3 to 365/366 days, unless otherwise provided in the Insurance Policy.

VI. Insurance cover (definition of the insured case)

6.1. The Insurer provides the Insured (insured persons, insured family members – collective contract for insuring a group of travellers) with financial compensation, in kind or mixed, upon the occurrence of the main insured risks referred to in item 6.2 of these contractual conditions, and upon the occurrence of the ancillary insured risks referred to in item 6.3 of these contractual conditions, if the Insured has opted for this cover.

6.2. In accordance with the clauses of the concluded Insurance Contract for "cover against main risks", an insured case may be deemed to be the occurrence of the events set out in the "insurance of financial losses" clause, as follows:

6.2.1. Financial losses related to medical treatment expenses where the disruption of the Insured's health, condition, or sudden illness is acute in nature, occurred unexpectedly, accidentally, and took place during the valid insurance period, on the territory indicated in the insurance policy, and where the event, for the elimination of the consequences of which the insurance was taken out, requires the medical assistance necessary and sufficient to save life or reduce pain, and is limited to:

a) outpatient medical assistance (Polyclinic, Medical Centres) provided as a result of sudden illness, including:

- emergency medical assistance, including emergency medical-surgical assistance and ambulance services;
- general practitioner consultation: medical history; general clinical examination; specific clinical examination;
- specialist doctor consultation;
- functional and laboratory investigations for the purpose of diagnosing the acute illness or condition, in accordance with the treating physician's instructions;
- radiology, endoscopy, ultrasound, sonography, scintigraphy, radioisotope, and other investigations necessary to establish a diagnosis;
- minor surgical interventions performed on an outpatient basis (polyclinic);
- medicinal treatment prescribed by the treating physician, procedures;
- calling a doctor to the place of accommodation, if travel to the medical institution recommended by the Assistance Company is not possible;
- medical staff fees;

b) inpatient medical assistance provided as a result of sudden illness, including:

- emergency hospitalisation;
- internist consultation;
- specialist doctor consultations;

- treatment in hospital conditions, including medical supplies and medication prescribed by the treating physician for the period of hospitalisation, procedures, accommodation (hotel) costs, medical staff fees;
- laboratory investigations, functional diagnostics, including radiology, endoscopy, ultrasound, sonography, scintigraphy, radioisotope and other investigations prescribed by the treating physician in accordance with the clinical protocol;
- emergency surgical interventions in inpatient conditions;
- local, loco-regional, or general anaesthesia;
- medical assistance in specialised intensive care and resuscitation units;

c) medical assistance provided as a result of the acute exacerbation of a pre-existing condition (chronic illness) is limited to emergency measures to save the Insured's life or measures aimed at relieving acute pain, up to a maximum limit of EUR 500, in accordance with the medical documentation and findings attesting to the emergency condition.

6.2.2. Financial losses related to medical evacuation in the event of an accident or illness, which include and are limited to the transportation of the Insured by ambulance or another specialised means of transport to another medical institution for the treatment of bodily injury or the sudden illness suffered, in circumstances where the Insured cannot be guaranteed medical care adequate to their state of health at the institution where they are hospitalised, and this fact endangers the Insured's life — provided within the limits of the sum insured.

6.2.3. Financial losses related to medical repatriation in the event of an accident or illness, which include and are limited to the transportation of the Insured from abroad by ambulance (or another specialised means of transport) to the Republic of Moldova or to the medical institution nearest to their home, and the assistance of an accompanying person, if such accompaniment is indicated in accordance with the treating physician's prescription. Repatriation expenses are included in the amount of compensation related to the occurrence of the insured event and do not exceed the limits of the sum insured.

6.2.4. Financial losses related to repatriation of mortal remains — actual expenses, approved by the Insurer, related to the transportation of the Insured's body following their death as a result of an accident or sudden illness, which include and are limited to:

- the actual costs, not exceeding the sum insured for this risk, related to the autopsy of the deceased, where this is mandatory in accordance with the clinical protocol or other regulations of the country in which death occurred;
- the actual costs, not exceeding the sum insured for this risk, related to embalming the Insured's body, necessary and sufficient for its transportation to the Republic of Moldova, carried out in accordance with the carrier's requirements or other international regulations;
- the actual costs, not exceeding the sum insured for this risk, related to the cost of the coffin and the transport case for the body to the Republic of Moldova;
- the actual costs, not exceeding the sum insured for this risk, related to the completion of accompanying documents for the transportation of the body to the Republic of Moldova;
- the actual costs, not exceeding the sum insured for this risk, related to loading the body onto transport (air, land, sea) for delivery to the Republic of Moldova;
- the actual costs, not exceeding the sum insured for this risk, related to transporting the body to the Republic of Moldova.

6.2.5. In addition to the exclusions provided for in Chapter VII of these contractual conditions, the Insurer, under the "Main Risks Insurance" cover, does not indemnify or compensate expenses for medical treatment, medical evacuation, medical repatriation, or repatriation of mortal remains provided for and/or arising as a consequence of:

a) alcoholism, drug addiction, substance abuse, or their direct consequences;

- b) dental treatment, except for emergency dental treatment, up to a maximum cover limit of EUR 150 for such cases;
- c) orthopaedic treatment, including the use of orthopaedic devices or techniques;
- d) orthodontic treatment, the making or repair of artificial teeth, the fitting of crowns, the fitting or repair of bridges, planned maxillofacial surgical or dental treatment;
- e) trauma, illness, or poisoning and their consequences suffered by the Insured while under the influence of alcohol, drugs, or toxic substances, the premeditated commission of a crime, attempted suicide, or self-harm, except where such a state of mind was caused to the Insured by the unlawful acts of third parties;
- f) infectious diseases: hepatitis A, B, C, D, E, tuberculosis, TORCH infections, mycoses, scabies, pediculosis, and other diseases provided for in the interstate agreements in force;
- g) treatment of sexually transmitted diseases, including HIV/AIDS and their complications, regardless of the clinical form and degree of development, gonorrhoea, syphilis, trichomoniasis, mycoplasma, and others;
- h) diseases related to parasitic invasions: giardiasis, ascariasis, oxyuriasis, taeniasis, cysticercosis, diphyllobothriasis, sparganosis, etc., and other diseases provided for in the interstate agreements in force;
- i) oncological diseases, including haemoblastoses, regardless of their clinical form and degree of development;
- j) mental illnesses and their complications, and various traumas and somatic diseases arising from mental illnesses;
- k) tuberculosis, sarcoidosis, cystic fibrosis, collagenoses, regardless of their clinical form and degree of development;
- l) chronic renal failure requiring haemodialysis;
- m) chronic hepatic failure;
- n) sexual disorders, infertility, artificial insemination, contraception;
- o) hereditary diseases and congenital abnormalities, regardless of their clinical form and degree of development;
- p) diabetes mellitus and its complications;
- q) acute and chronic actinic conditions;

The Insurer also does not compensate expenses related to:

- r) planned treatment of chronic diseases, including planned surgery, known or unknown, suffered by the Insured, treated or untreated prior to the conclusion of the Voluntary Health Insurance Contract for Travel Abroad, including treatment of such diseases at the outpatient care stage;
- s) medical assistance related to an epidemic or pandemic officially recognised in the country/countries to which the Insured is travelling;
- t) treatment of infectious diseases that could have been prevented in advance by vaccination and/or that result from the Insured Person's breach of quarantine/prophylactic measures after contact with a carrier;
- u) rehabilitation, homeopathic, reflexotherapy, or manual therapy treatment, or treatment of an experimental nature;
- v) transplantation of cells, tissues, and organs;
- w) cardiac surgery, angiography, stent placement, coronary artery bypass (angioplasty);
- x) cosmetic and plastic surgical procedures and operations, cosmetic/plastic prosthetics, sex reassignment;
- y) monitoring of pregnancy and its complications;
- z) medical assistance at childbirth and its complications, except for sudden complications endangering the life of the pregnant woman and/or foetus during pregnancy up to 30 weeks, and where the pregnant woman is under 38 years of age (the Insurer will cover the medical expenses incurred directly to remove this danger, up to a maximum limit of EUR 500.00);
- aa) curettage or minor abortions, unless these are the consequence of an accident or an emergency necessity;

- bb) the fitting of medical prostheses of any kind, including vascular prosthetics;
- cc) hospital stays for custodial and rehabilitation care;
- dd) vision correction, surgical treatment of myopia, hyperopia, astigmatism, or the purchase or repair of glasses or contact lenses;
- ee) the purchase or repair of medical devices and equipment (means of transport, pacemakers, or any temporarily or permanently implanted device);
- ff) antiviral treatment;
- gg) rehabilitation and/or curative-sanatorium treatment;
- hh) medical treatment where the Insured Person undertook the trip abroad for the purpose of obtaining medical services for the treatment of a pre-existing illness: an illness or condition of which the Insured and/or their family were aware prior to the insurance cover under these contractual conditions taking effect, or treatment applied for the consequences of a workplace injury or occupational disease;
- ii) chemotherapy and/or radiotherapy treatment;
- jj) immunomodulatory treatment;
- kk) disinfection, prophylactic vaccination, medical expert examinations, and instrumental and/or laboratory investigations, unless these are a direct consequence of the accident or acute sudden illness;
- ll) the provision of additional comfort in the ward, namely: a ward with several separate rooms, television, telephone, additional air conditioning and humidifying equipment, hairdressing, massage, or beautician services, etc.;
- mm) treatment administered without coordination with the Assistance Company or the Insurer, except for the circumstances provided for in item 6.2.6 c) of these contractual conditions;
- nn) treatment administered after the expiry of the valid insurance period, or treatment administered upon return to the Republic of Moldova or the country of residence;
- oo) preventive or routine medical check-ups, medical screening.

6.2.6. Upon the occurrence of the main insured risk, the Insured or the person representing their interests, in accordance with the documents of the concluded Contract and the issued Insurance Policy, shall:

a) notify the Assistance Company or the Insurer by telephone (the telephone numbers are stated in the Insurance Contract) of the occurrence of the insured event.

b) identify themselves by stating:

- the name of the insurance company whose Policy they hold;
- surname, first name;
- the series and number of the insurance policy;
- the event that occurred;
- the address and telephone number at which the Insured can be contacted;
- the terms of the insurance period;

c) where it is not possible to follow the sequence of actions mentioned above (before consulting a doctor or being hospitalised), the Insured or the person representing their interests is required to report the occurrence of the insured case to the Assistance Company, or to notify the Insurer at the telephone number indicated in the Insurance Policy, as soon as possible but no later than 72 hours from the time of consulting a doctor. Where the Assistance Company or the Insurer is not notified by the Insured at the telephone and fax numbers provided within a maximum of 72 hours, and there are no documents justifying the delay in notification, the Insurer will pay the Insured's medical and transport expenses arising from an accident or illness up to a maximum amount of EUR 500, if the event is deemed to be an insured case.

Extension:

Regardless of the provisions of these contractual conditions, where the Insured's life is endangered, the Insured or any other person representing their interests must arrange emergency transportation by all possible means to the nearest medical institution, and then notify the Insurer or the Assistance Company.

d) Where the Insured fails to notify the Assistance Company or the Insurer of the occurrence of the insured event before the end of medical treatment (main risk insurance), the Insurer is entitled to request written explanations regarding the situation that has arisen, and reserves the right to make the final decision regarding compensation of the expenses incurred.

e) Where the Insured, for objective reasons, does not contact the Assistance Company, or where it has been mutually agreed with the Insurer that the Insured will personally contact any other medical institution, and the Insured personally pays the cost of the medical service, the Insured must submit to the Insurer (at the Company's head office), within 30 calendar days of returning to Moldova, a Claim Form, to which the following must be attached without exception:

- the original Insurance Policy or a copy thereof;
- the original invoice issued by the medical institution (on company letterhead or bearing the corresponding stamp);
- the medical report from the doctor/institution that provided the services, stating the patient's name, diagnosis, date on which medical assistance was requested, duration of treatment, itemised list of services provided with dates and costs, and total amount due;
- the prescriptions issued by the doctor in connection with the accident or illness suffered (in original, stamped by the pharmacy, indicating the cost of the medication purchased);
- the original documents confirming payments for treatment, medication, and other services (stamp confirming payment, cash receipt, or bank receipt indicating the amount transferred);
- the international passport and a copy thereof;
- a copy of the identity card;
- other documents, as applicable.

f) In order to settle claims for compensation under the "repatriation of mortal remains" main risk insurance, the person representing the Insured must notify the Assistance Company or the Insurer of the occurrence of the insured risk. Within 30 calendar days of repatriation to Moldova, at their own expense, the Insured's relatives must submit a claim for compensation drawn up on the basis of the expenses incurred by the Insured's close relatives, together with the mandatory enclosure of:

- the document certifying death;
- the official certificate attesting the cause of death;
- in the case of an accident, the documents relating to the circumstances of death;
- the death certificate;
- the documents confirming the expenses referred to in item a) of clause 6.2.4 of these contractual conditions;
- other documents, as applicable.

6.3. After receiving all the documents referred to above from the Insured, the Insurer will finalise the settlement of the claim file within 30 calendar days of the date of submission of the last document, with payment of the insurance indemnity within this period or the issuing of a decision to refuse the claim.

6.4. In accordance with the clauses of the concluded Insurance Contract, cover for main risks may be supplemented by "cover for ancillary risks", indicated in the insurance policy.

6.5. Cover for main risks begins at 00:00 on the first day of the insurance period stated in the insurance policy, but not before the Insured crosses the border of the Republic of Moldova (the crossing being authenticated by the border services), provided that the insurance premium has been paid in full.

6.6. Insurance cover ends at 24:00 on the last day of the insured period stated in the Insurance Policy, or at the moment of re-entry into the territory of Moldova during the valid period of the voluntary health insurance for travel abroad.

VII. Events excluded from insurance cover

7.1. The Insurer does not provide insurance cover and, accordingly, does not indemnify loss or damage caused directly or indirectly, resulting "from" or "in connection with", or contributing to, or resulting from:

- a) the imposition of a state of war; civil war; revolution or a state of emergency;
- b) invasion; foreign intervention;
- c) military hostilities (declared or undeclared), rebellion, insurrection;
- d) civil unrest amounting to an uprising;
- e) the establishment of military rule or the usurpation of power;
- f) biological or chemical contamination;
- g) the explosion of shells, bombs, or grenades, as a consequence of any act of terrorism;
- h) enlistment in the armed forces or employment in the service of other military formations;
- i) active or passive participation in acts of terrorism or war, as well as joining a terrorist organisation.

7.2. The Insurer does not assume any obligations under the insurance and, accordingly, does not pay insurance compensation where the Insured, during the period of validity of the Insurance Contract, commits acts classified by law enforcement authorities as a crime or offences that gave rise to the occurrence of the Insured Case.

7.3. The Insurer does not assume any obligations under the insurance and, accordingly, does not pay insurance compensation where the Insured, during the period of validity of the Insurance Contract, commits acts that gave rise to the occurrence of the insured case or were the cause of its occurrence, namely:

- a) falsified data in the completed Insurance Application;
- b) failed to inform, or informed with delay, the Assistance Company (the Insurer's partner) about the occurrence of the insured event where the state of health permitted verbal communication, and benefited from medical or other services such as evacuation, repatriation, or inpatient treatment lasting more than 10 days, provided in connection with the Insured's sudden illness or accident, without informing the Insurer and obtaining its consent regarding the validity of the contract and the coverage of expenses;
- c) engaged in high-risk professional activities, recreational or professional sports, participated in competitions, training camps, or sports training, is employed abroad, or engages in gainful activity involving physical labour or a high-risk professional activity, and this fact led to the occurrence of the insured risk (exception – declaring this fact and the application of increased coefficients in calculating the insurance premium when the Contract was concluded);
- d) became intoxicated with alcohol, drugs, medication, or toxic substances, administered in breach of applicable health and safety guidelines;
- e) suffers from the consequences of a suicide attempt;
- f) piloted or travelled on a means of transport other than a scheduled one (aircraft, yacht, racing vehicle), except where travelling as a passenger on board a civil carrier operated by a professional pilot or another licensed specialist;
- g) was enlisted in the armed forces or employed in the service of other military formations;
- h) actively or passively participated in acts of terrorism or war;
- i) is a member of a terrorist organisation.

7.4. It is understood that this insurance does not qualify as an "Insured Case" (unless otherwise provided by contract), and excludes compensation for expenses directly or indirectly related "to", resulting "from", or "in

connection with" circumstances that have contributed or contribute to the occurrence of the insured risk (including disruption of the Insured's state of health) in the event of the direct or indirect effect of nuclear energy.

7.5. The Insurer does not pay sums insured and/or insurance compensation where the insurable interest is unlawful, or where the loss suffered is caused by, or is a consequence of, such unlawful interest.

7.6. The Insurer's refusal to pay the compensation or the sum insured may be challenged by the Insured (Policyholder) in a court of law.

7.7. Where the Insurer contends that, within the meaning of this exclusion, any expenses are not covered by this insurance, the burden of proving otherwise rests with the Insured.

VIII. Sum insured

8.1. The voluntary health insurance for travel abroad stipulates the sum insured in monetary equivalent, the value of which is classified according to the territorial extent of the insurance, and which may be negotiated at the time the insurance contract is concluded.

8.2. The sum insured is the Insurer's maximum financial obligation towards the Insured, expressed as an amount (the sum insured for main risk cover and the sums insured for ancillary risk insurance), denominated in hard currency – euro, agreed at the time the Insurance Contract is concluded and entered in the Insurance Policy under the heading "Sum insured".

8.3. The sum insured under the voluntary health insurance for travel abroad is established per person.

8.4. The sum insured is stipulated in the Insurance Policy.

8.5. The sum insured represents the maximum indemnity limit, which may not be lower than the minimum threshold approved by the Insurer, namely:

LIABILITY LIMITS PER PERSON — SUM INSURED					
	Zone A	Zone B	Zone C	Zone D	Zone E
Total sum insured, including medical expenses, medical evacuation, medical repatriation	EUR 5,000	EUR 10,000	EUR 30,000	EUR 40,000	EUR 50,000
Repatriation of mortal remains	EUR 2,000	EUR 3,000	EUR 4,500	EUR 5,000	EUR 7,000

8.7. The sums insured stated in the Insurance Policy (Contract) (for main risk and/or ancillary risk insurance) are reduced by the amount of any prior payments, where the Insured or the Beneficiary of the insurance has already been compensated for risks that have occurred.

IX. Insurance premium

9.1. The insurance premium is the amount which the Policyholder is required to pay to the Insurer upon issue of the insurance policy, in the manner and within the term provided for by the Insurance Contract, in exchange for the Insurer's assumption of the insured risk.

9.2. The insurance premium in monetary equivalent is calculated on the basis of the insurance tariff in force at the time the Insurance Contract is concluded. The value calculated in hard currency is converted into national currency on the basis of the hard currency exchange rates set by the National Bank of Moldova on the date the Insurance Contract is concluded.

9.3. Insurance premiums and tariffs are calculated by the Insurer. The specific amount of the insurance tariff is established in the Insurance Contract by mutual agreement of the parties.

9.4. The amount of the insurance premium calculated for main risk and ancillary risk cover may be increased through the application of increasing coefficients where persons engaged in high-risk activities are insured, or reduced through the application of a technical discount (family contracts, collective contracts – insurance of a group of tourists or a group of children).

9.5. The value of the insurance premium, represented by the amount of the premiums calculated for main risk cover and the premiums for ancillary risk insurance, is entered in the Insurance Policy under the heading "Insurance premium".

9.6. The insurance premium is paid in full, as a single payment, in cash or by bank transfer.

9.7. Payment of the insurance premium is made in full, at the registered office of the Insurer or its representative offices, unless the parties have agreed otherwise in writing.

9.8. Proof of payment of the insurance premium is the responsibility of the Policyholder and/or the Insured, any document proving payment provided for by the legislation in force being deemed evidence of payment.

9.9. Liability for failure to pay insurance premiums on time and in full rests with the Policyholder (the Insured).

X. Rights and obligations of the Insured

10.1. The Insured/Policyholder has the right to purchase voluntary health insurance cover for travel abroad, which may include cover for main risks and cover for ancillary risks.

10.2. Under the concluded Insurance Contract, the Insured has the right to:

- a) become acquainted with these contractual clauses and the Insurance Conditions;
- b) conclude Voluntary Health Insurance Contracts for Travel Abroad as a Policyholder in favour of third parties (Collective Contracts), or in favour of members of their own family (Family Contract), or for themselves (Individual Contract), on the basis of these contractual conditions;
- c) benefit from services related to the event that occurred, in accordance with these contractual conditions, where the event has been classified as an "insured case";
- d) submit claims for compensation or payment of the sum insured upon the occurrence of the insured case;
- e) receive insurance compensation, paid in accordance with the findings regarding the insured case or its consequences;
- f) receive, in the event of loss of the Insurance Contract, a duplicate thereof, upon payment of the cost of the newly issued form;
- g) initiate the procedure for terminating the Contract.

10.3. Where the Policyholder of the insurance is a person other than the Insured, the Policyholder has the same obligations as those assigned to the Insured under the concluded Contract, while its rights are limited to:

- a) concluding the Insurance Contract in favour of third parties and paying the corresponding insurance premium;
- b) initiating the procedure for terminating the Insurance Contract, provided the following condition is met: the validity of the Contract has not expired and the Insured(s), during the period of validity of the insurance preceding the moment of termination, has/have not received insurance compensation under this Contract.

10.4. The Insured/Policyholder is obliged to:

- a) be personally present when the Insurance Application is drawn up and/or personally complete the insurance application;
- b) give the Insurer the opportunity to verify the circumstances relating to the insurance on the basis of these contractual conditions;
- c) pay the insurance premium in the amount calculated on the basis of the insurance tariffs in force at the time the Contract is concluded, within the periods established prior to departure on the trip, respectively before the

start of the insurance period;

d) ensure the safekeeping of the documents drawn up by the parties involved in the contractual relationship;

e) comply with the instructions of the doctor and of the Assistance Company/Insurer relating to the settlement of the insured case;

f) inform the Insurer, at the time the Insurance Contract is concluded and/or during the period of validity of the Contract, of all material circumstances relating to the insured risk or any change in the circumstances affecting it. Those hazardous circumstances that could influence the Insurer's decision regarding the conclusion of the Insurance Contract (pre-existing illnesses or conditions, planned treatment or medical interventions, the purpose of the trip, the high-risk activities to be carried out abroad) are considered material;

g) give the Insurer the opportunity to verify the circumstances relating to the conduct of the insurance on the basis of these contractual conditions;

h) grant the Insurer the right to verify the state of health of the Insured or of the insured persons under the concluded Insurance Contract;

i) inform the Insurer of the occurrence of the insured risk as soon as they become aware of it, and in cases beyond the injured party's control (serious state of health, lack of telephone network, etc.) – within no more than 30 calendar days from the date of consulting a doctor or returning to the Republic of Moldova;

j) follow and comply with the treating physician's instructions;

k) release the doctors of medical institutions from the obligation to maintain confidentiality towards the Insurer's representatives in respect of the Insured's state of health, in relation to data requested during the procedure for establishing the insured case;

l) take such action as is within their control to prevent the occurrence of the insured case or to limit the damage caused by its occurrence;

m) notify the Insurer in writing of the loss of the Policy or of the Insurance Contract issued.

10.5. The Policyholder (other than the Insured) is obliged to:

a) provide genuine information, corresponding to reality, subsequently used in the decision-making process regarding the insurance, by completing the Insurance Application for this purpose;

b) provide the Insurer with the details of the insured persons, stating their names and surnames, identification number, date of birth, travel document number, territory of insurance, insured risk(s), the value of the sum insured, the period of insurance cover, as well as the insured persons' consent to the processing of personal data, which is presumed to have been given at the time the insurance application is completed;

c) be liable for the accuracy of the information provided in the insurance application towards the Insurer and the insured persons.

XI. Rights and obligations of the Insurer

11.1. In accordance with this concluded Contract, the Insurer provides the Insured (the Policyholder) with cover for main risks, related to disruption of health, resulting in medical assistance or medical treatment costs administered to the Insured, and for ancillary risks.

11.2. The Insurer guarantees:

a) confidentiality, in respect of insured persons;

b) the organisation of the provision of timely and adequate medical services to Insured persons in the event of an accident or sudden, acute illness;

c) cover for ancillary risks, where this cover has been purchased by the Policyholder.

11.3. In accordance with these contractual conditions, the Insurer has the right to:

a) conclude voluntary health insurance contracts for travel abroad with natural persons, citizens of the Republic of Moldova and stateless persons, or with legal persons, on the basis of the insurance application,

personally completed by the Insured (Policyholder);

b) assess the accuracy of the data set out in the insurance application, as well as the Insured's compliance with the contractual clauses;

c) pay compensation of up to EUR 500 where the Insured has received medical services and personally paid (in cash) for the cost of the service without immediately informing the Insurer of the occurrence of the insured event, or without prior coordination with the Insurer or the Assistance Company, where the case is deemed to be an insured case under the contractual provisions;

d) request, where necessary, for the purpose of assessing the risks accepted for insurance, prior to the conclusion of the Insurance Contract, that a medical examination be carried out on the persons to be insured;

e) verify the information provided in the insurance application regarding the risks to be insured;

f) decline to conclude the Insurance Contract on the basis of the underwriting assessment of the risks to be insured;

g) apply increasing coefficients to the tariff when calculating the insurance premium, on the basis of information about the insurance applicant or the risks for which cover for main risks or ancillary risks is selected, as reflected in the insurance application;

h) apply pre-established coefficients when calculating the insurance premium;

i) verify the Policyholder's (Insured's) fulfilment of the requirements and provisions of the Insurance Contract;

j) subject to medical examination and documentation both the diagnoses established for the Insured and the treatment prescribed, when settling claims under main risk cover;

k) amend or terminate the Insurance Contract in accordance with the provisions of the insurance contract and the legislation in force.

11.4. The Insurer is obliged to:

a) familiarise the Policyholder (the Insured) with these contractual insurance clauses;

b) issue the Insured with the Insurance Policy after collecting the insurance premium;

c) contribute to the timely and quality provision of medical and/or advisory assistance to the Insured(s) upon the occurrence of the insured case, on the basis of these Insurance Conditions and in accordance with the concluded Contract;

d) pay compensation or sums insured in accordance with the decision adopted for settling the claim;

e) defend the interests of Insured persons regarding the timely, complete, and quality provision of assistance services.

XII. Impossibility of performance due to force majeure

12.1. Failure to perform contractual obligations, or improper performance thereof, may not be attributed to the contracting parties where this is caused by events making performance impossible, which could not have been foreseen at the date the contract was concluded, or where the parties could not prevent their occurrence or remove their effects. The following shall be deemed instances of impossibility of performance due to force majeure:

a) military action of any kind;

b) economic sanctions imposed at international level;

c) popular or civil unrest;

d) any other event beyond the parties' control, namely a situation invoked by the party prevented from fulfilling its contractual obligations, generated by an external, unforeseeable, absolutely unavoidable, and inevitable event, and evidenced by documents issued by the competent public authorities. By way of illustration and without limitation, the Insurer does not compensate for damage caused by: weather events, natural disasters, epidemics, pandemics, strikes, political and armed conflicts, catastrophic situations, public

danger, terrorist attacks, international embargoes, as well as cases where airlines unilaterally set liability limits or make changes to schedules or itineraries.

12.2. The party invoking impossibility of performance due to force majeure is required, within 3 days of the occurrence of the event invoked, to notify the other party of the occurrence of the event.

12.3. Where impossibility of performance due to force majeure occurs, the time limits for performing contractual obligations shall be extended for an additional period equal to the period during which the impossibility of performance due to force majeure persists.

XIII. Validity of the Insurance Contract

13.1. The voluntary medical assistance insurance contract is the freely agreed arrangement, concluded between the Insured and the Insurer, by which legal relationships are established, amended, or terminated.

13.2. The Insurance Contract is concluded for the period indicated in the insurance policy and takes effect at 00:00 on the day following the day on which the insurance premium was received in the Insurer's account.

13.3. The Contract may be amended or terminated only in accordance with its clauses or by agreement of the parties, unless the law provides otherwise.

13.4. Amendment of the clauses of the Insurance Contract is carried out by written agreement of the parties, confirmed by the signatures and seals of the contracting parties.

13.5. Either party, the Policyholder or the Insurer, is entitled to initiate the procedure for terminating the concluded insurance contract, without invoking grounds of non-performance, before the expiry of its period of validity, by giving the other party 45 calendar days' written notice before the termination date.

13.6. The Insurance Contract may be terminated on the Insurer's initiative, with written notice given to the Policyholder 14 days before termination of the contract, where the Policyholder/Insured breaches the obligation to disclose all material circumstances or an aggravation of the insured risks. Termination is excluded where the inaccuracy was known to the Insurer or where the statement was made inaccurately through no fault of the Insured. In such a case, the Insurer may only terminate the contract within 1 (one) month of becoming aware of the inaccuracy.

13.7. Termination is carried out by written statement of the Insurer, and the insurance premium paid will be refunded to the payer without any deductions.

13.8. The Insurer terminates the Insurance Contract on the Policyholder's initiative within no more than 30 days, where the insurance period has not expired and the Insurer has not paid any sums insured or insurance compensation under the Contract being terminated.

13.9. Where the Insurance Contract is terminated at the Policyholder's request, the insurance premium paid will be refunded to the payer in a reduced amount. The Insurer will withhold the amount calculated from the cost of insurance for the elapsed period of the Insurance Contract, together with the amount of the Insurer's administrative expenses.

13.10. The Insurance Contract lawfully terminates by mutual agreement of the parties, as well as:

- a) upon the Insured's failure to pay the insurance premium in the amount and within the period established in the insurance contract and the legislation in force;
- b) upon expiry of its period of validity (at 24:00 on the last day of the insurance period);
- c) upon fulfilment by the Insurer of its contractual obligations (payment in full of the sum insured or fulfilment of contractual obligations per insured case);
- d) upon liquidation of the Insurer, in the manner established by law;
- e) in other cases provided for by law;
- f) the Insurance Contract is void in cases provided for by legislation, or if it was concluded under conditions contrary to the legislation in force.

13.11. In the event of absolute nullity of the insurance contract, the Insurer shall refund in full to the Insured the insurance premiums received, and the Insured who has benefited from the insurance compensation shall refund in full the amounts received.

XIV. Assumption by the Insurer of the Insured's rights (subrogation)

14.1. By paying the insurance indemnity (the actual loss), the Insurer acquires, within the limits of that amount, the right of claim which the Insured or another person who received the insurance indemnity holds against a third party responsible for causing the loss.

14.2. If the Insured recovers part of the loss from the third party at fault for the occurrence of the insured case, the Insurer is released from paying that part of the compensation.

14.3. Where the entire loss caused to the Insured has been compensated by the party at fault, or where there is a final court judgment for recovery of the loss from the party at fault, the Insurer is released from the obligation to pay the insurance compensation.

XV. Jurisdiction for dispute resolution

15.1. Disputes arising in connection with the performance of the Insurance Contract shall be settled amicably by the parties, and where agreement cannot be reached, shall be settled by the competent court, in the manner established by the legislation of the Republic of Moldova.

15.2. Before filing a claim in court, the relevant party is required to submit a duly substantiated demand to the other party.

15.3. The demand and the response thereto must be sent by post (registered mail) or delivered by courier with confirmation of receipt.

15.4. The party to whom the demand is addressed is required to respond to the demands raised within 30 days. The time limit for responding begins to run from the moment the demand is received.

15.5. The Insurance Contract is concluded in accordance with the legislation of the Republic of Moldova and is governed by the jurisdiction of the Republic of Moldova in any country, in the event of disputes, where the applicable law shall be that of the Republic of Moldova.

15.6. This contract is concluded in the Romanian language, and where the Insurer provides a translated copy of the insurance contract in Russian or English, in the event of any discrepancies, the provisions in the Romanian language shall prevail.

XVI. Particulars of the parties

The identification details of the Insurer and of the Policyholder, together with the signatures of the parties, are recorded in the insurance policy issued upon conclusion of the Contract.