ACCIDENT INSURANCE REGULATIONS

Approved by Resolution of the Board of ADB Compensa Vienna Insurance Group of 4 September 2018, applicable from 26 February 2019

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1. Terms and definitions

1.1. For the purpose of these Regulations, the following terms and definitions shall apply:

1.1.1. **Insured person** – means the person specified in the insurance contract to whom, upon occurrence of an insured event in his life, the Insurer must pay an insurance benefit. In the insurance contract, the insured persons may be identified as: a) natural persons; b) employees working at the insured workplaces or holding a certain job position.

1.1.2. **Self-defence** – means physical defence of a person against dangerous attempt to infringe the interests fostered by him within the meaning of the Criminal Code of the Republic of Lithuania.

1.1.3. **Policyholder** – means the person who applies to the Insurer for the conclusion of an insurance contract or who is offered by the Insurer to conclude an insurance contract or who has concluded an insurance contract with the Insurer.

1.1.4. **Insurer** – ADB Compensa Vienna Insurance Group.

1.1.5. **Change of underwriting risk** – means the cases when the number of insured persons / workplaces specified in the insurance contract (or its annex), the nature of work of the insured person(s) changes, when the insured person starts engaging in sports (Sports, Professional Sports or Extreme Sports) or chooses a different type of sports than that specified in the insurance contract, becomes disabled, falls ill with a mental illness, is declared incapable by the court, contracts any serious and incurable disease.

1.1.6. **Extreme sports** – means the types of sports that require technical equipment or facilities. The following shall be attributed to the life-threatening type of sports: martial arts and contact sports types, such as boxing, wrestling and analogous branches of sports); piloting of flying apparatuses (gliding, acrobatic flying, paragliding, piloting of hot air balloons or other light aircraft; types of air sports (parachuting, power kiting and similar sports branches/activities); types of water sports (scuba-diving with equipment, sea yachting, white water rafting, surfboarding and analogous sports branches/activities); car and motorcycle sports; bicycle sports, mountain cycling sports, BMX bicycle sports; training in which a firearm is used; speleology, expeditions to mountains, jungles, deserts or other uninhabited territories; alpinism; bungee jumping; riding a motorcycle of more than 74 kW (100 AG) engine power.

1.1.7. **Sports** – means participation in sports exercises, trainings or competitions of any type organised by a sports organisation, including additionally chosen sports exercises that are not a mandatory part of the educational programme. Sports organisations shall include: sports centres, sports schools, sports bases, sports federations, associations and societies, other organisations and institutions engaged in sports activities that provide conditions for practicing physical training and sports, training sportsmen, organising sports competitions and other events of physical training and sports.

Individual or group sports exercises that are attended for health promotion purposes, constitute a part of the educational programme, or which are chosen by the insured person just as a way of spending free time shall not be considered to be sports, provided that the insured person does not participate in competitions, marathons and such a way of spending free time does not constitute the aggravated risk activity within the meaning of these Regulations.

1.1.8. **Beneficiary** – means the person specified in the insurance contract and/or designated by the insured person who in the case of the insured event becomes entitled to the insurance benefit. Where the Beneficiary is not identified, the Insured person shall become the beneficiary (the Insured person's legitimate successor). The Beneficiary shall be designated in accordance with the procedure established by laws of the Republic of Lithuania.

1.1.9. **Being under the influence of alcohol** – means the state of being under the influence of alcohol when the person's blood concentration of alcohol exceeds 0.6 ‰ (in the event of driving a motor vehicle – when blood concentration of alcohol exceeds the quantity specified in the Code of the Republic of Lithuania of Administrative Offences).

1.1.10. **Accident** – means an unexpected, sudden event during which the Insured person's body is affected by external physical force against the Insured person's will (including chemical, thermal, toxic gas or other physical impact) causing damage to the Insured person's health or leading to his death.

Accidents shall also include accidental acute medium or serious poisoning with food, drugs, chemicals, gas, steam, poisonous plants or mushrooms occurring against the insured person's will.

1.1.11 **Professional sports** – activities of the Insured person who regularly engages in any type of sports for payment (excluding the cases that are considered to be the Extreme sports).

1.1.12**. Trauma** – means the Insured person's bodily injury / health impairment as a result of an accident.

1.1.13. **Consumer** – means a natural person who seeks concluding or concludes contracts for the purposes unrelated to his business, crafts or profession (consumption purposes).

2. Insurance object and underwriting risks

2.1. The insurance object shall be the Insured person's or Beneficiary's property interests relating to the occurrence of underwriting risks covered by the insurance contract.

2.2. Main underwriting risks:
2.2.1. Death;
2.2.2. Disability;
2.2.3. Traumas;
2.2.4. Critical diseases;
2.2.5. Other illnesses and surgeries.
2.3. In addition to the selected Main underwriting risks the Policyholder may include one or more Supplementary underwriting risks.
2.4. Supplementary underwriting risks:
2.4.1. Medical expenses;
2.4.2. Assistance insurance;
2.4.3. Hospital allowance;
2.4.4. Temporary disability (daily allowance);
2.4.5. Loss of job;
2.4.6. Crisis management expenses – only when employees are insured by employers.

3. Description of the main underwriting risks

3.1. Death
3.1.1. In the case of the underwriting risk of death, the insured event shall be the Insured person's death occurring within 12 (twelve) months following the accident occurring during validity of the insurance cover.
3.1.2. In the event of the Insured person's death caused by the insured event, the insurance benefit shall make up 100% of the sum insured for the underwriting risk of death specified in the insurance policy.

3.2. Disability
3.2.1. In the case of underwriting risk of disability, the insured event shall be the declaration in accordance with the procedure established by legal acts of the RL, within 12 (twelve) months following the accident occurring during validity of the insurance cover, of the Insured person's disability (for persons under 18 years of age), capacity for work of up to 86% (for persons from 18 years until retirement age) or special needs of SP1 or SP2 level (for persons of retirement age), where the reason for that is the accident occurring during validity of the insurance cover.
3.2.2. If the Insured person becomes disabled because of the insured event, the insurance benefit shall be calculated according to the Table below:

Persons under 18 years of age	**Persons from 18 years until retirement age**	**Persons of retirement age**	**Calculated insurance benefit (% from sum insured established for underwriting risk of disability)**
Severe disability	0-25% capacity for work	High social needs	100%
Medium disability	26-45% capacity for work	Moderate social needs	70%
Mild disability	46-85% capacity for work	Low social needs	50%

3.2.3. Where the capacity for work established for the Insured person is 86-100%, it shall be considered that the person is capable to work, and the insurance benefit shall not be paid according to the underwriting risk of disability.
3.2.4. Where it is established that the Insured person was totally or partially incapacitated for work already before the insured event, the insurance benefit shall be calculated according to the actual decrease of capacity for work due to the insured event (i.e. the difference between the capacity for work before and after the insured event shall be assessed).

3.3. Traumas

3.3.1. Traumas may be insured according to 2 variants:
3.3.2. Traumas of bones and joints – in the case of this underwriting risk, the insured event shall be the Insured person's bodily injury / health impairment during the insurance cover validity period caused by trauma specified in Annex No 1 to the Regulations.
3.3.3. Traumas of bones and joints and injuries of internal organs and soft tissues: in the case of this underwriting risk, the insured event shall be the Insured person's bodily injury / health impairment during the insurance cover validity period caused by trauma, specified in Annex No 1 or Annex No 2 to the Regulations.
3.3.4. Upon occurrence of the insured event covered by underwriting risk of Trauma, the insurance benefit shall be calculated as a percentage specified in Annex No 1 and/or Annex No 2 for the respective injury from the sum insured determined for this underwriting risk.
3.3.5. The insurance benefit shall also be paid for actual costs of plastic surgery performed in order to eliminate the consequences of trauma in the amount of up to 10% of the sum insured established for the underwriting risk of trauma.

3.4. Critical illnesses
3.4.1. In the case of the underwriting risk of critical illnesses, the insured event shall be the critical illness specified in Annex No 3 diagnosed for the Insured person for the first time during validity of the insurance cover, but not earlier than 3 (three) months after the date on which the insurance cover enters into force.
3.4.2. Upon occurrence of the insured event according to the underwriting risk of critical illnesses, the insurance benefit shall be equal to 100% of the sum insured established for this underwriting risk.

3.5. Other illnesses or surgeries
3.5.1. In the case of the underwriting risk of other illnesses or surgeries, the insured event shall be the illness specified in Annex No 4 diagnosed for the Insured person for the first time or the surgery specified in Annex No 4 performed for the first time during validity of the insurance cover.
3.5.2. Upon occurrence of the insured event according to the underwriting risk of other illnesses or surgeries, the insurance benefit shall be equal to 100% of the sum insured established for this underwriting risk.
4. Description of supplementary underwriting risks
4.1. Where the Policyholder selects supplementary underwriting risks (paragraph 4 of the Regulations), the insurance benefit on the basis of these regulations shall be paid only where the occurrence of such supplementary underwriting risks is inextricably associated with the insured event under the Underwriting risks of Death, Disability or Trauma.

4.2. Medical expenses
4.2.1. Upon occurrence of the insured event, the insurance benefit shall be paid for medical treatment services and medical aids supported by medical documents provided by in-patient health care institutions of the Republic of Lithuania, where they are not compensated from the compulsory health insurance fund:
4.2.2. Medicines, orthopaedic devices registered by the State Medicines Control Agency – up to EUR 100 per event;

4.2.3. Rent and acquisition of wheelchairs – up to EUR 200 per event;
4.2.4. Diagnostic tests (laboratory, functional, radiological, instrumental), necessary for confirming the traumas and prescribing the treatment – ne up to EUR 200 per event;
4.2.5. Suturing and dressing of wounds, injections, infusions - up to EUR 100 per event.

4.3. Assistance insurance
4.3.1. Upon occurrence of the insured event in the case of insurance of the Underwriting risk of Assistance the insurance benefit shall be paid for:
4.3.1.1. Burying or cremation – in the case of death – indemnified shall be actually incurred expenses supported by documents for burying or cremation of the Insured person as well transportation of the Insured person's body;
4.3.1.2. Adaptation of the living environment – in the case of disability - indemnified shall be actually incurred expenses supported by documents for adapting the living environment for the Insured person;
4.3.1.3. Psychologist's consultation – in the case of the Insured person's disability or death – indemnified shall be actually incurred expenses supported by documents for the psychologist's services provided to the Insured person, his/her spouse, children and parents; however, for not more than 10 visits in respect of one event and not exceeding EUR 600 for the insurance contract validity period. In the cases of assault, physical violence, rape of the Insured person these expenses shall be indemnified only where the Insured person has immediately applied to law enforcement bodies in respect of such acts;
4.3.1.4. Childminder's expenses – in the case of trauma, death – indemnified shall be expenses for services of a childminder of the Insured person's minor children deprived of adult care; however, not more than EUR 50 per day and not exceeding EUR 600 for the insurance contract validity period.
4.3.1.5. Journey to a hospital – reasonable, actually incurred expenses supported by document for urgent transportation (from medical point of view) of the Insured person to a health care institution because of trauma.

4.4. Hospital allowance
4.4.1. Where this underwriting risk is chosen, in the case of the insured event, the insurance benefit shall be the daily sum insured specified in the insurance policy paid for each day spent in an in-patient health care institution; however, not exceeding 30 (thirty) days in a row and for not more that 180 days during the insurance contract validity period.
4.4.2. The insurance benefit shall not be paid for short-term (up to 3 (three) days inclusive) in-patient medical treatment periods.
4.4.3. The duration of the in-patient medical treatment period shall be determined on the basis of extracts from medical records produced to the Insurer.

4.5. Temporary incapacity for work (daily allowance)
4.5.1. Where the Policyholder chooses the supplementary underwriting risk of the temporary incapacity for work (daily allowance), in the case of the insured event the daily sum insured specified in the insurance policy shall be paid for each day of the Insured person's temporary incapacity for work; however, not exceeding 30 (thirty) days of incapacity for work due to the same Trauma and not more than for 60 (sixty) days during the insurance contract validity period:
4.5.1.1. the duration of the Insured person's temporary incapacity for work shall be the period in which the Insured person, during validity of the insurance cover and for not more than 10 (ten) days after its expiry, was temporarily incapacitated for work because of Trauma suffered by him or because of Trauma suffered by a pre-school or school age child covered by the same insurance contract (when the Insured person's temporary incapacity for work is related with the need to look after the child who suffered Trauma);
4.5.1.2. the Insurance benefit shall not be paid for short-term (up to 6 (six) days inclusive) periods of incapacity for work;
4.5.1.3. the Insurance benefit shall not be paid when the causal link between the insured event and the temporary incapacity for work is not supported by medical records and when during the period of the temporary incapacity for work the Insured person worked or attended an educational institution, travelled abroad, failed to follow the regime prescribed by a doctor;
4.5.1.4. Duration of the of the temporary incapacity for work shall be determined on the basis of the certificate of incapacity for work issued by health care institutions to the Insured person, certificates for nursing of the sick family member or certificates on absence from an educational institution, labour exchange or workplace (F 094/a).

4.6. Loss of job
4.6.1. Where the Policyholder chooses the supplementary underwriting risk of the loss of job, in the case of the insured event the insurance benefit shall be calculated as follows:
4.6.1.1. 100% of the sum insured provided for the underwriting risk of the loss of job shall be paid;
4.6.1.2. the Insurance benefit shall be paid only when the Insured person according to the conclusion issued by a medical service or the Disability or Working Capacity Assessment Office under the Ministry of Social Security and Labour s unable to hold such position or remain in such job, or where due to temporary disability the Insured person is absent from work for the number of days specified in the law and the employment contract with him was terminated on this basis;
4.6.1.3. the Insurance benefit shall not be paid upon termination of a partnership, project work, second job or additional employment contracts.

4.7. Crisis management costs
4.7.1. Where the Policyholder (employer) selects this clause as a supplementary underwriting risk and the insured event of Death, Disability is suffered by the Insured person – the policyholder's employee – at work during validity of the insurance cover, the Insurer shall indemnify the associated necessary costs of the employer supported by documents for:
4.7.1.1. lawyers who represent the employer before public authorities or the Insured person;
4.7.1.2. additional consultations on occupational safety;
4.7.1.3. communications;
4.7.1.4. expenses for the Insured person's funeral;
4.7.1.5. the psychologist's, social, medical assistance provided to the Insured person or his family members for up to 2 (two) months after the insured event;
4.7.1.6. the search for, and training of, a new employee.
4.7.2. Where the insurance benefit may be paid under several underwriting risks applicable to the insurance contract (e.g., assistance, medical expenses), the insurance benefit for this risk shall be disbursed only when the limits established for other risks are exceeded.

5. Non-insured events and losses not eligible for indemnity

5.1. An event shall be considered to be the non-insured event where the Insured person's trauma / health impairment / death was caused or influenced by:
5.1.1. the Insured person's injuries or diagnosed diseases / health disorders, any innate illnesses, innate and adaptive physical or developmental

defects; disturbances of consciousness or mental disorders occurring before the conclusion of the insurance contract (in the case of continuous extension of the insurance contract – before the conclusion of the first insurance contract);
5.1.2. the Insured person's engagement in the aggravated risk activity (Chapter VI of the Regulations) not covered by the insurance policy;
5.1.3. the Insured person's, Policyholder's, Beneficiary's or their related persons' intentional acts or actions including elements of intentional criminal acts;
5.1.4. the Insured person's suicide (excluding the cases when the insurance contract was valid for more than 3 (three) years), attempted suicide, deliberate self-harm;
5.1.5. the Insured person's being under the influence of alcohol, drugs or other psychotropic substances, consumption of energy drinks, use of strong medicines without the doctor's prescription related to the occurrence of the accident by causal link;
5.1.6. operation of a motor vehicle by the Insured person under the influence of alcohol, drugs or other psychotropic substances or without the driving license;
5.1.7. transfer by the Insured person of the operation of a motor vehicle to a person who does not hold the required driving license or is under the influence of alcohol, drugs or other psychotropic substances; as well as deliberate driving of the Insured person in a motor vehicle operated by a person who does not hold the required driving license or is under the influence of alcohol, drugs or other psychotropic substances (i.e. when the Insured person is or should be aware of such a situation);
5.1.8. the Insured person's involvement in a fight (except in the cases of self-defence and performance of the official duties within the limits of granted powers), participation in unlawful races or competitions;
5.1.9. an accident resulting from use of a firearm or other weapon or ammunition by the Insured person, the Policyholder, or the Beneficiary, except in the cases of self-defence and assault (when the Insured is a victim), unless the contract establishes otherwise;
5.1.10. an accident occurring because of use by the Insured person of any explosives that are not used in the household or explosive materials and/or devices attributable to this category;
5.1.11. acts of foreign enemies, military acts (irrespective of whether war is declared or not), terrorism, civil war, overturn or usurpation of power, mass commotions, rebellion, revolution, riot, strike, lockout;
5.1.12. lawful detention, apprehension or arrest of the Insured person;
5.1.13. performance by the Insured person of military service or participation in military operations or exercises;
5.1.14. radiation or other exposure to nuclear energy ionising radiation;
5.1.15. earthquake, hurricane, tsunami or other natural disasters.
5.2. Under the conditions set forth in these Insurance Regulations, the insurance benefit shall not be paid with respect to:
5.2.1. medical aids and services not supported by medical documents;
5.2.2. incurred non-property damage;
5.2.3. damage caused by health care services of poor quality;
5.2.4. transplantation of internal organs when the Insured person was entered on the transplantation list or was aware of the need for transplantation before concluding the insurance contract;
5.2.5. medullar transplantations, haemodialysis procedures;
5.2.6. health impairments caused by degenerative alterations and treatment of osteochondrosis;
5.2.7. acquisition of spectacles, lenses and items for their maintenance services;
5.2.8. costs of acquisition of thermometers, inhalers, testers, warmers, hearing aids, scales, blood pressure monitors, glucose meters.
5.2.9. food additives, anabolic steroids, weight loss drugs, contraception and articles for hygiene, medications and aids for treatment of various substance abuse conditions.
5.2.10. The Insurance contract shall not cover any other risks that do not meet the criteria of Trauma (Annexes No 1 and 2 to the Regulations), Critical illnesses (Annex No 3 to the Regulations) or other Illnesses and surgeries (Annex No 4 to the Regulations) and the insurance benefit in respect of them shall not be paid (e.g., minor injuries, bruises, scrapes, superficial, uncomplicated wounds, etc.).

6. Aggravated risk activities

6.1. The aggravated risk activities shall be covered by the insurance contract only where this was explicitly agreed upon at the time of its conclusion and is specified in the insurance policy. The aggravated risk activities shall include:
6.1.1. Sports;
6.1.2. Professional sports;
6.1.3. Extreme sports.
6.2. Where the Policyholder selects the Professional sports activities, the insurance cover shall also apply to the Insured person who engages in Sports; where the Extreme sports activities are chosen, the insurance cover shall also apply to the Insured person who engages in Sports or Professional sports.
6.3. Where the Policyholder does not choose the aggravated risk activities in the insurance contract, the insurance cover shall apply only when the Insured person does not engage in Sports, Professional sports or Extreme sports.
6.4. Where the Policyholder – a legal person – concludes a group insurance contract whereby the employees are insured according to the list of positions, the insurance cover shall apply to all employees entered on such list (including the newly recruited employees) during validity of their employment contracts concluded with the Policyholder.
All employees on the list attached to the insurance policy who were dismissed the insurance cover shall automatically cease from the day of their dismissal (termination of employment).
At the end of the Insurance contract (or on other dates specified in the insurance contract) the Policyholder shall submit to the Insurer the data and, at the Insurer's request, also the documents supporting them about changes in the numbers of insured employees of the Policyholder during the previous period. Where the total number of the insured employees changes by 15 %, the Insurer shall recalculate the annual insurance premium on the basis of the submitted data, proportionately to the number of the insured employees. Where the Policyholder, who is a legal person, concludes a group insurance contract whereby employees are insured according to the name list, the application of insurance cover to a particular insured person shall begin or terminate only when the Policyholder notifies the Insurer in writing.

7. Insurance benefit calculation and payment

7.1.The Insurance benefit amount shall be calculated in the manner described in the descriptions of underwriting risks.
7.2. Insurance benefits payable in the cases of the underlying underwriting risks with respect to the same health impairment / illness / surgery shall not be summed up. Where, by virtue of conditions of these Regulations, the Insured person or the Beneficiary is eligible to different insurance benefits for the same cause (e.g., Trauma, the Disability resulting from such Trauma and later occurring Death), one of the insurance benefits – the largest – shall be disbursed. Where, before the disbursement of the largest insurance benefit, another insurance benefit had already been paid

out with respect to the same health impairment / illness / surgery, the latter shall be deducted from the insurance benefit payable later.
7.3. All sums insured shall not be revolving, i.e. after disbursement of the insurance benefit for the particular underwriting risk, the Insurer's liability with respect to other insured events under the same underwriting risk to the same Insured person shall be reduced by the amount of already disbursed insurance benefits.
7.4. The person applying to the Insurer for the disbursement of the insurance benefit must submit:
7.4.1. the personal identity document;
7.4.2. the report of the format established by the Insurer about the event and its circumstances;
7.4.3. medical records supporting the fact and circumstances of the insured event and changes in the Insured person's health condition;
7.4.4. documents issued by public authorities investigating the event (e.g., a statement of accident at work or on the way to/from work, a police certificate, etc.);
7.4.5. the death certificate and inheritance right certificates (in the cease of the Insured person's death); a certificate about disability / level of capacity for work / special needs (in the case of the Insured person's disability);
7.4.6. Other documents requested by the Insurer in writing.
7.5. The Insurance benefit shall be disbursed no later than within 30 (thirty) days of the day of submission to the Insurer of all documents necessary for determining the circumstances of the insured event and calculation of the insurance benefit.
7.6. The Insurance benefit shall be disbursed to:
7.6.1. the Insured person (in the case of death – to legal heirs) or to the Beneficiary designated by the Insured person;
7.6.2. in the event of the Beneficiary's death occurring before the insured event, the insurance benefit shall be distributed proportionately to other Beneficiaries, and where the latter do not exist – to the Insured person (legal heirs). in the event of the Beneficiary's death after the insured event, the insurance benefit shall be disbursed to legal heirs;
7.6.3. the Insurance benefit according to the underwriting risk of the Crisis management costs shall be disbursed to the Policyholder.
7.7. The calculated insurance benefit shall be reduced by the outstanding part of the insurance premium the term of payment of which is expired on the insurance benefit payment day. Where after payment of the insurance benefit the insurance contract expires, the insurance benefit shall be reduced by the total amount of the outstanding insurance premium irrespective of its payment deadlines.

8. Cases of reduction and refusal of the insurance benefit

8.1. The Insurance benefit shall not be paid when the event is a non-insured event or does not fall within the scope of the insurance cover.
8.2. The Insurer shall have the right to refuse or reduce the insurance benefit, where it is established that when concluding the insurance contract the Policyholder provided wrong information which has lead to the incorrect assessment of the underwriting risk.
8.3. Upon increase of the underwriting risk, the Insurer shall have the right to request to change the terms and conditions of the insurance contract or to increase the insurance premium. Where, in such case, the Policyholder objects to the change of the terms and conditions of the insurance contract or to the increase of the insurance premium, the Insurer shall be entitled to apply to the court for the termination or amendment of the insurance contract due to essential change of circumstances. The failure to notify the Insurer of the aggravated risk shall constitute a breach of the insurance contract, and the Insurer shall have the right to terminate the insurance contract, as provided for in Chapter 10 of these Regulations, and to reduce the insurance benefit or to completely refuse to pay it where the cause of the insured event or increase of damage is the circumstances not reported to the Insurer which have lead to the aggravated the underwriting risk.
8.4. The Insurer shall have the right to refuse the insurance benefit, where the Policyholder, the Insured person or the Beneficiary fails to fulfil written instructions of the Insurer, avoids or refuses to cooperate, does not provide assistance or hinders the investigation of circumstances of the event or act otherwise in order to receive the insurance benefit in unauthorised manner.
8.5. The Insurance benefit shall not be disbursed in the case of delayed visit to a health care institution for treatment, or delayed reporting of the event to the Insurer as a result of which the Insurer cannot verify the date of circumstances of such event.
8.6. The Insurer shall have the right to refuse or reduce the insurance benefit where the Policyholder, the Insured person or the Beneficiary defaulted on the obligations provided for under Chapter 9 of the Regulations.
8.7. Where, in the case of loss insurance, there is double insurance (i.e. several insurance contracts are concluded for the same object), the insurance benefit shall be paid pro rata to the ratio of sums insured under all insurance contracts.
8.8. Insurer shall have the right to refuse the insurance benefit and request repayment of already disbursed insurance benefit, where due to actions of the Policyholder, the Insured person, the Beneficiary or their related persons the Insurer is unable to implement the right of claim to the person liable for damage which transfers to the Insurer.
8.9. In the case of loss insurance, the insurance benefit shall be reduced by the amount indemnified to the injured party by other persons.
8.10. The Insurance benefit shall not be paid where its payment would infringe the regulation of trade, economic or other sanctions or embargos applied by the organisations of the Republic of Lithuania, EU or international organisations, or other national or international legal acts applicable to the Insurer's business.
8.11. The Insurance benefit shall not be paid when the Insured person has been declared by the court as unknown or missing.

9. Rights and obligations

9.1. Obligations of the Policyholder
9.1.1. To provide to the Insurer accurate, complete and correct information necessary for the assessment of the underwriting risk and conclusion of the insurance contract. The essential circumstances which must be reported by the Policyholder to the Insurer shall be:
9.1.1.1. the usual place of residence of the Policyholder and the Insured person;
9.1.1.2. the aggravated risk activities;
9.1.1.3. the Insured person's health condition (diagnosed mental illnesses, existing or previous other diseases, the disability / incapacity for work established for the Insured person, the need for nursing or care, the total or limited incapacity established for the Insured person);
9.1.1.4. In the case of loss insurance (when the insurance benefit depends on the amount of actually incurred losses) – the information about insurance contract concluded with respect to the same insurance object;
9.1.1.5. Other information indicated in the application of the form established by the Insurer for conclusion of the insurance contract, or requested by the Insurer to be provided in writing.
9.1.2. In cases when Insured person is other than Policyholder, Insured persons data related to his health is given to Insurer for risk evaluation only with Insured persons consent;

9.1.3. To pay insurance premiums within the time limits fixed in the insurance contract.
9.1.4. To familiarise the Insured person and the Beneficiary with the terms of insurance, inform them about the insurance cover termination.

9.2. Obligations of the Policyholder and the Insured person:
9.2.1. To fulfil reasonable written requests of the Insurer; to grant the Insurer access to the information relevant for the assessment of the underwriting risk.
9.2.2. To notify the Insurer, within 3 (three) working days, of the change in circumstances relevant for the assessment of the underwriting risk (Chapter VI of the Regulations).
9.2.3. Upon occurrence of the event which may be recognised to be the insured event:
9.2.3.1. To take available reasonable measures in order to reduce the amount of damage.
9.2.3.2. No later than within 48 (forty-eight) hours, to visit a heath care institution; fulfil all instructions and recommendations of medical specialists.
9.2.3.3. Where the event occurs as a result of activities that include the elements of a crime or administrative offence, to immediately report to the police;
9.2.3.4. No later than within 30 (thirty) days, to report in writing to the Insurer the event which may be recognised to be the insured event;
9.2.3.5. To provide the Insurer with correct information about the causes, circumstances of the insured event and amount of damage, the documents supporting the insured event as well as all other insured event related documents necessary for determining the circumstances of the insured event and amount of damage or needed by the Insurer in order to implement his right of claim to the person liable for damage; to follow all written instructions given by the Insurer;
9.2.3.6. To give consent to the Insurer to obtain from health care institutions a copy of the Insured person's medical records, other documents and information about services provided and medicines prescribed to the Insured person; to specify contact details of medical specialists and health care institutions who treated the Insured person; at the request of the Insurer, in order to determine or update the diagnosis or degree of impact on health, to visit the medical institution or medical specialist specified by the Insurer for the performance of examination or clinical tests.

9.3. Obligations of the Beneficiary:
9.3.1. To provide to the Insurer all documents and information about the circumstances and consequences of the insured event.
9.3.2. The Insurer shall have the right to request the implementation of the insurance contract by the Beneficiary where it has not been implemented by the Policyholder, and the Beneficiary has brought to the Insurer the claim for payment of the insurance benefit.
9.3.3. To notify the Insurer of the Insured person's death within 14 (fourteen) days.

9.4. Rights of the Policyholder:
9.4.1. To request to change the insurance contract in accordance with the procedure set out in legal acts and in the insurance contract.
9.4.2. To terminate the insurance contract at any time.
9.4.3. Where the policyholder is a consumer – to waive the insurance contract concluded by means of communication within 14 (fourteen) days following practical guidance of the Insurer published on the Insurer's Internet Website: www.compensa.lt.

9.5. Rights of the Insured person and the Beneficiary:
9.5.1. In the case of the insured event, to claim from the Insurer the disbursement of the insurance benefit in accordance with the procedure set out in legal acts and in the insurance contract.
9.5.2. To be informed about the progress of investigation of the insured event.

9.6. Obligations of the Insurer:
9.6.1. To provide information to the Policyholder about the Insurer's name, the type and address of the insurance undertaking, the address of the Insurer's branch or representative (where the insurance contract is concluded not at the registered office of the Insurer), the procedure of investigation of disputes arising from or in relation to the insurance contract, the Insurer's actions if the Policyholder breaches terms and conditions of the insurance contract, possible instances of the aggravation of risk.
9.6.2. Upon occurrence of the insured event, to disburse the insurance benefit in accordance with the procedure set out in legal acts and in the insurance contract.
9.6.3. To prove the circumstances relieving the Insurer from disbursement of the insurance benefit or entitling the Insurer to reduce the insurance benefit.

9.7. Rights of the Insurer:
9.7.1. To refuse concluding the insurance contract when the underwriting risk is unacceptable;
9.7.2. To request from the Policyholder and the Insured person the information necessary for the assessment of the underwriting risk; when determining the amount of the insurance premium to take account of the events which had occurred earlier.
9.7.3. Upon increase of the underwriting risk during validity of the Insurance contract, to request to pay an additional insurance premium, and in the event of the Policyholder's refusal to pay it – to demand the termination of the insurance contract.
9.7.4. In accordance with the procedure set out in legal acts, to process personal data of the Policyholder, the Insured person, and the Beneficiary; to request and receive from health care institutions, law enforcement bodies, public registers, and banks the information necessary for examining the application for conclusion of the insurance contract, administration of the event which may be recognised to be the insured event.
9.7.5. To refuse or reduce the insurance benefit the cases specified in the Regulations.
9.7.6. To demand the repayment of unduly disbursed insurance benefit (its part).

10. Insurance contract conclusion, enforcement, performance and termination

10.1. The Insurance contract shall be concluded in writing, and its conclusion shall be confirmed by the insurance policy issued by the Insurer. Prior to the conclusion of the insurance contract, the Policyholder, at the request of the Insurer, must complete and submit the application of the form and content established by the Insurer for concluding the insurance contract. The Policyholder must ensure the correctness of data specified in the application.
10.2. The Insurance contract shall be concluded by signing it by both parties, or by signing it by the Insurer and by payment by the Policyholder of the total insurance premium or its first instalment provided for in the insurance contract.

10.3. The insurance cover validity period, geographical coverage and sums insured shall be determined by agreement of the parties and specified in the insurance policy.
10.4. The Insurance contract shall enter into force from the date specified in the insurance policy, but not earlier than upon payment of the total insurance premium or its first instalment provided for in the insurance contract. The partial payment of the insurance premium (or payment of the first instalment of the insurance premium, where its payment is arranged in instalments) shall not be considered to be the proper fulfilment of the obligation to pay the insurance premium and shall be respectively subject to the provisions of paragraph 11 of the Regulations.
10.5. The Insurance contract may be amended y written agreement of both parties.
10.6. The Insurance contract stall expire upon:
10.6.1. expiry of the insurance cover validity period specified in the insurance contract;
10.6.2. death of the Insured person (except where there are more Insured persons under the same insurance contract);
10.6.3. termination of the insurance contract by agreement of the parties;
10.6.4. termination of the insurance contract on the Policyholder's initiative. For the purposes of this subparagraph, the insurance contract shall be deemed to be terminated 10 (ten) days after receiving by the Insurer of a written request to terminate the insurance contract, or on the day specified in the request (if such date is later);
10.6.5. termination of the insurance contract on the Insurer's initiative on the grounds provided for by legal acts or the insurance contract. For the purposes of this subparagraph, the insurance contract shall be deemed to be terminated from the date specified in the Insurer's notification of the termination of the insurance contract;
10.6.6. In other cases provided for by laws.

11. Calculation, payment and refund of insurance premiums

11.1. The amount of the insurance premium shall be determined by the Insurer taking account the insurance rates, chosen underwriting risks, sums insured, insurance cover validity term, other factors relevant for the underwriting risk. The amount of the insurance premium and its payment deadlines shall be indicated in the insurance policy.
11.2. The insurance premium payment day shall be the day of receiving the money (where payment is made in cash) or the day of crediting the funds to the Insurer account (where payment is made by a payment order).
11.3. The Policyholder's obligation to pay insurance premiums shall survive the termination of the insurance contract.
11.4. Consequences of the delay of the insurance premium payment term:
11.4.1. Where the payment term of the total insurance premium of the first insurance premium (when payment of the insurance premium is arranged in instalments) specified in the insurance policy is overdue for up to 30 (thirty) days, the insurance cover shall enter into effect within 72 (seventy-two) hours after payment of the insurance premium.
11.4.2. Where the payment term of the total insurance premium of the first insurance premium (when payment of the insurance premium is arranged in instalments) specified in the insurance policy is overdue for more that 30 (thirty) days, the insurance cover shall not enter into effect.
11.4.3. Where the payment term of the second or any subsequent insurance premium is overdue for more that 30 (thirty) days, the Insurer shall have the right to terminate the insurance contract, notifying the Policyholder in advance in writing within the time limits specified by legal acts.
11.5. The cases of refund of the insurance premium:
11.5.1. Where the insurance contract does not enter into force – the total amount of paid insurance premium shall be refunded.
11.5.2. Where the insurance contract is terminated on agreement of the parties – the insurance premium shall be refunded according to the conditions specified in such agreement.
11.5.3. Where the contract is terminated on the Policyholder's initiative – the part of the paid annual insurance premium, proportionate to the period remaining until the end of the insurance cover validity period specified in the insurance contract shall be refunded. The Insurer shall have the right to reduce the refundable amount the contract administration and performance fee which is calculated according to the formula: $(0.3 \cdot Į) + Ž – S$, where Į – the part of the annual insurance premium proportionate to the period remaining until the end of the insurance cover validity period specified in the insurance contract, Ž – the sum of insurance benefits disbursed and to be disbursed under such insurance contract, S – the amount recovered by the Insurer by subrogation.
11.5.4. In the event of the Insured person's death not due to the insured event – the part of the paid annual insurance premium, proportionate to the period remaining until the end of the insurance cover validity period specified in the insurance contract shall be refunded.
11.5.5. In other instances the insurance premium shall not be refunded.
11.6. At the request of the Policyholder, the refundable insurance premium or its part may be transferred to the settlement account specified by the Policyholder (no later than within 14 (fourteen) days of the day of receiving the Policyholder's written request) or set off against the insurance premium under other insurance contract concluded with the Insurer.

12. Notifications

12.1. Any notification communicated by one party to the insurance contract to the other party shall be provided in writing. On agreement of the parties, a notification delivered by e-mail shall be treated as a written notification and as an appropriate method of communication.
12.2. A notification shall be considered to be delivered appropriately, where it is sent:
12.2.1. to the Insurer: by e-mail: zalos@compensa.lt or info@compensa.lt; by registered mail to the Insurer's registered office address specified on the Internet Website: www.compensa.lt;
12.2.2. to the Policyholder or Insured person: by e-mail of the Policyholder or Insured person indicated in the insurance policy; by registered mail to the address of the Policyholder or Insured person indicated in the insurance contract.
12.3. Where the Insurer receives a notification about the change of the Policyholder's residence address, e-mail or phone, further notifications shall be sent to the new residence address. Notifications sent by the Insurer to the old residence address of the Policyholder until the day on which the notification about the change of the Policyholder's residence address is received shall be considered to be delivered appropriately.
12.4. A notification shall be considered to be delivered on the working day following its sending (in the case of a notification sent by e-mail) or on the day of its actual delivery (in the case of a notification sent by registered mail).

13. Other provisions

13.1. The Insurance contract shall be governed by the law of the Republic of Lithuania.
13.2. The matters not contemplated in these Regulations shall be ad-

dressed in observance of provisions of the Civil Code, the Law on Insurance and other applicable legal acts.
13.3. Disputes arising with respect to the insurance contract shall be settled according to the Insurer's Dispute Settlement Rules published on the Internet Website: www.compensa.lt. Where a dispute is not settled peacefully, it shall be referred to the courts of the Republic of Lithuania. Disputes between the Insurer and a consumer may be settled by the Bank of Lithuania (www.lb.lt; Žirmūnų g. 151, LT-09128, Vilnius).
13.4. In the cases established and provided for by laws, the Insurer's rights and obligations under the insurance contract may be transferred to another insurance undertaking, to an insurance undertaking or its branch of another Member State of the European Union or foreign country. The Insurer must notify the Policyholder of the intention to transfer the rights and obligations under the insurance contract in accordance with the procedure set out by the Law on Insurance and/or other applicable legal acts. The Policyholder who objects to the transfer of the rights and obligations under the insurance contract shall have the right to terminate the insurance contract, within one month of the day of transfer of the rights and obligations under insurance contract (in that case, the Policyholder shall be refunded the total unused part of the insurance premium without charging the contract administration and performance fee).

ANNEXES

Annex 1
Traumas of bones and joints. Table for determining the insurance benefit amount

Annex 2
Traumas of internal organs and soft tissues. Table for determining the insurance benefit amount

Annex 3
Critical illnesses. Table for determining the insurance benefit amount

Annex 4
Other illnesses and surgeries. Table for determining the insurance benefit amount

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Nicolas Mucherl
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