COMPENSA INSURANCE TERMS AND CONDITIONS FOR PERSONS ENTERING THE REPUBLIC OF LATVIA NO. CNR 4.2.15

This translation of terms and conditions is for information purposes only. Terms and conditions only in Latvian language is in force for Insurance agreement.

(Approved in Compensa Vienna Insurance Group UADB 2015 28 December Board)

SECTION 1. TERMS

1. EXPLANATION OF TERMS

1.1. INSURER – Compensa TU S.A. Vienna Insurance Group Latvijas filiāle, registration no. 40103587577, address: Mūkusalas iela 101, Riga, LV-1004.

1.2. POLICY HOLDER – a legal or physical person that has concluded an Insurance agreement on its or other person's behalf.

1.3. INSURED – a person indicated in the Insurance policy that shall have insurance interest and for benefit of which the Insurance agreement has been concluded.

1.4. INSURANCE AGREEMENT – an agreement of the Policy holder and Insurer wherewith the Policy holder shall undertake liabilities to pay the Insurance premium in a form, terms, and amount set in the agreement, as well as fulfil other contractual liabilities, while the Insurer shall undertake liabilities to pay the Insurance indemnity to the person indicated in the agreement in compliance therewith upon occurrence of an Insurance case. The Insurance agreement shall consist of an Insurance policy and insurance terms and conditions.

1.5. INSURANCE INDEMNITY – an amount to be paid for the Insurance case or for costs of the provided services.

1.6. INSURANCE CASE – an unexpected and unplanned event that does not depend on will of the Insured and that is causally related to the Insured risk when upon occurrence thereof, it is foreseen to pay the Insurance indemnity in compliance with provisions of the Insurance agreement.

1.7. INSURANCE OBJECT – a person's life, health or physical condition, material values, or interests.

1.8. INSURANCE PERIOD – a period of time of validity of the Insurance agreement.

1.9. INSURANCE PREMIUM – a payment for insurance stipulated in the Insurance agreement.

1.10. INSURED RISK – an event indicated in the Insurance agreement and does not depending on will of the Insured whose occurrence in future is possible.

1.11. SUM INSURED – the maximum amount of money indicated in the Insurance agreement that the Insurer might be obliged to pay to one Insured upon occurrence of an Insurance case.

1.12. INSURANCE LIMIT – a Sum insured specially stipulated in the Insurance agreement that is a maximum Insurance indemnity for a particular Insured risk.

1.13. INDEMNITY LIMIT – maximum insurance indemnity for one insurance case for a particular Insured risk indicated in the Insurance agreement.

1.14. INSURANCE POLICY OR POLICY – a written document or electronic print-out approving conclusion of the Insurance agreement.

1.15. TERRITORY OF INSURANCE – a geographical territory indicated in the Insurance policy where the Insurance agreement is valid. The Insurance agreement shall be valid in the Republic of Latvia and other Schengen countries (Austria, Belgium, Denmark, Finland, France, Germany, Italy, Greece, Luxembourg, the Netherlands, Portugal, Spain, Sweden, Norway, Iceland, the Czech Republic, Estonia, Lithuania, Malta, Poland, Slovenia, Slovakia, Hungary, Switzerland).

1.16. EMERGENCY MEDICAL CARE – medical care when non-provision thereof would cause be dangerous to life of the Insured.

1.17. SUDDEN SEVERE ILLNESS – unexpected and inexperienced before the Insurance period disease that needs Emergency medical care to be provided to the Insured.

1.18. CHRONIC DISEASE – gradually developing and/or periodically repeating disease regardless whether or not such health condition has been diagnosed before the start of validity of the Insurance agreement.

1.19. EXACERBATION OF CHRONIC DISEASE – sudden onset of symptoms typical to chronic disease or rapid worsening progress during the Insurance period when eventually the Insured needs Emergency medical care.

1.20. ACCIDENT – an event that is sudden, independent on will of the Insured, and causal to influence of external powers occurred during the validity of the Insurance agreement resulting in damage to health or life of the Insured with a necessity of Emergency medical care.

1.21. REPATRIATION – medically reasoned and accepted by the Insurer transportation of the Insured or his/her remains to his/her Country of residence.

1.22. COUNTRY OF RESIDENCE – the country, which is the Insured person's country of citizenship or permanent residence, or the country that has issued a residence or permanent residence permit, except the Republic of Latvia.

1.23. DEDUCTIBLE – a share of loss indicated in the Insurance policy in terms of money or interest that is deducted from the compensable losses when calculating the Insurance indemnity for each Insurance case or that is covered by the Insured. Deductible shall always be defined as for each Insured.

1.24. EUROPEAN HEALTH INSURANCE CARD (EHIC) – European health insurance card acknowledging rights to receive necessary Emergency medical care to the same extent as provided to people that are residents of that country.

1.25. MEDICAL PRACTITIONER – a certified medical practitioner that has received a certificate of the medical practitioner and obtained rights to work in a particular specialism of medicine.

1.26. DISTANT INSURANCE AGREEMENT – an Insurance agreement that is concluded by the Insurer and Policy holder based on a written offer of the Insurer or an invoice, or through a brochure, and advertisement in press with an order voucher, telephone, internet, e-mail, television, radio, or other information sending or transmission means. Payment of an Insurance premium made by the Policy holder, Insured person, or any other person on behalf or in interests of the Policy holder, indicating the number of the Insurance agreement, policy, or invoice, shall be an approval of conclusion of the Distant insurance agreement.

1.27. RECOURSE – rights of claim against the person that is responsible for the losses or causing thereof.

SECTION 2. INSURED RISKS

2. MEDICAL EXPENSES

2.1. Medical expenses as for these provisions shall be emergency medical costs incurred to the Insured in the territory of the Republic of

Latvia or other Schengen countries for Emergency medical care in case of a worsening acute and dangerous to life health condition due to sudden illness, sudden exacerbation of chronic disease, or accident when such costs are not covered by the European Health Insurance Card or in compliance with other laws and regulations.

2.2. The Insurer shall compensate reasonable and documentary proved medical costs for received Emergency medical care as close as possible to the place of preventing an acute and dangerous to life condition or the place of sudden disease in relation to use of common medical methods of out-patient and/or in-patient care depending on nature of the disease defined and provided by a certified medical establishment or practitioner.

2.3. In addition to the medical expenses, the Insurer not exceeding the medical expenses Sum insured and insurance limit to each particular Insurance risk indicated in the Policy, shall compensate reasonable and documentary proved certain costs as for the following risks:

2.3.1. Dental treatment

2.3.1.1. The Insurer shall cover costs of emergency, pain relieving dental care that is opening of cavity abscesses, start of treatment of tooth root, placing a temporary filling, or extraction of a tooth during the first appointment.

2.3.2. Medical transport

2.3.2.1. Costs for transportation of the Insured to the nearest medical establishment shall be covered when Emergency medical care is needed in relation to worsening acute and dangerous to life health condition due to sudden illness, sudden exacerbation of chronic disease, or accident and when in compliance with a medical opinion of a Medical practitioner the Insured should be carried to a medical establishment.

2.3.3. Medical repatriation

2.3.3.1. The Insurer shall cover medically reasoned by a Medical practitioner and accepted by the Insurer costs for transporting the Insurer to his/her Country of residence when the transportation is needed in relation to worsening acute and dangerous to life health condition due to sudden illness, sudden exacerbation of chronic disease, or accident.

2.3.4. Repatriation in case of death

2.3.4.1. The Insurer shall cover accepted with it costs for transporting the remains of the Insured to the Country of residence in case of death of the Insured when caused in the result of sudden illness, sudden exacerbation of chronic disease, or accident.

2.3.4.2. The Insurer shall cover transportation costs to the border or airport (when transportation has been carried out by a plane) of the Country of residence of the Insured.

3. EXCLUSIONS

3.1. The Insurer shall not compensate losses:

3.1.1. for medical care when it is not related to emergency care for prevention of consequences of sudden disease or an accident and being dangerous to life of the Insured;

3.1.2. for planned dentistry – doctor consultations, dental treatment and prosthetic dentistry, implantology, X-ray diagnostics, medicines and aids used in treatment, cavity hygiene, treatment of parodont diseases;

3.1.3. for medical expenses in relation to pregnancy, including abortion of the pregnancy, labour and postnatal complications;

3.1.4. for medical care in relation to diagnostics and treatment of diseases, including chronic diseases when the Insured fell ill before concluding the Insurance agreement regardless whether or not the disease was diagnosed before conclusion of the Insurance agreement, except for emergency medical care in order to save life of the Insured;

3.1.5. treatment of chronic diseases, except for the first Emergency medical care during validity of the Insurance policy;

3.1.6. for treatment of psychiatric, psychotherapeutic, sexopathology, sexually transmitted disease, HIV/AIDS, as well as alcoholism, drug addiction, toxicomania, smoking, or diagnostics and treatment of damages to health caused thereof;

3.1.7. for medical care in relation to congenital, inherited disease, or illness that is contracted before conclusion of the Insurance agreement, for treatment of anomalies and oncology diseases whatever the stage of disease is;

3.1.8. in relation of medical rehabilitation, treatment in resorts and sanatoriums, high-comfort services, cosmetic treatment, plastic surgery, tissue and organ transplantation, prosthetics (incl. making, purchase, and repair of a prosthetic appliance), cardiovascular surgeries, untraditional treatment methods, anonymous treatment, treatment without a diagnosis or when the treatment does not correspond to a diagnosis or laws and regulations of the country of treatment;

3.1.9. for technical and medical aids and assistance devices;
medicines, homoeopathy remedies;

3.1.10. for any sufferer's repatriation costs or repatriation costs in case of death when such costs are not accepted by the Insurer or exceed the minimum amount that is needed for provision of transportation of the Insured or his/her remains to the Country of residence, as well as when caused due to health disorders mentioned in exclusions therein;

3.1.11. when the Insured does not observe instructions of a Medical practitioner.

3.2. The Insurance case shall not be and the Insurance indemnity shall not be paid when losses have been incurred:

3.2.1. in the result of war, invasion, or war-like action (regardless whether or not the war is declared), terror attacks, civil war, lockouts, public disorders, rebellions, riots, strikes, resistance movements, revolutions, military or other coups, establishment of curfew, or siege, or other situations resulting in a siege or establishment of curfew;

3.2.2. in the result of accepting laws and regulations and decisions of the state or municipalities, including but not limited to confiscation, alienation for the needs of the state, as well as in the result of destroying or damaging a property when authorised by public authority;

3.2.3. in the result of nuclear explosion, pollution of atomic energy, radiation, radioactive pollution, ionising radiation;

3.2.4. in the result of a global or regional natural disaster when the national or municipal institutions has declared an emergency situation in relation to mass victims (injured) or losses to economy, or damage to environment, or forced termination of economical activities, or when emergency and rescue work and preventive measures are to be performed;

3.2.5. in the result of malice, gross negligence, or unlawful action of the Insured, Policy holder, or other person who is interested in receipt of the Insurance indemnity;

3.2.6. in the result of intentional actions of the Insured, including suicide, suicide attempt, exposure to danger of the Insured, except for a case of saving life of a person.

3.3. The Insurance case shall not be and the Insurance indemnity shall not be paid if losses have been incurred:

3.3.1. when the Insured is under alcoholic, psychotropic, toxic, narcotic

substances, and other highs or medicines that have not been prescribed by a doctor;

3.3.2. when the Insured suffers in a road accident and the vehicle has been driven by the Insured him/herself without rights to drive the vehicle of the relevant category or being under alcoholic, psychotropic, toxic, narcotic substances, and other highs, as well as when the Insured has been on a vehicle that has been driven by a person without rights to drive the vehicle of the relevant category or being under alcoholic, psychotropic, toxic, narcotic substances, and other highs and the Insured has been informed thereon;

3.3.3. when the Insured participates in, carries out, or tries to carry out a criminal or administrative penal act;

3.3.4. when the Insured involves or participates in active military operations or drilling executing his/her duties and/or duties of a volunteer at police, border guards, fire rescue service, Home Guards, or any other militarised organisation or formation;

3.3.5. when the Insured works at nuclear reactors, decompression chambers, with toxic chemicals, production of explosives or ammunition, mining, working as a stevedore, being a member of a vessel's or plane's crew, working outside the range of a land, for instance on oil extraction platforms;

3.3.6. when the Insured flies any aircraft that is not owned by an airline or registered as a passenger aircraft for flights in a definite route;

3.3.7. when the Insured rides a motorcycle, motor scooter, quad, wave runner, carting;

3.3.8. when the Insured participates in such sports and activities as: mountain hikes exceeding 2,500 metre above sea level, rock climbing, mountain climbing, cave diving, diving with breathing equipment, underwater swimming, rafting, heli-boarding, parachuting, bungee jumping, or jumping with a special flying costume, kayaking, hang gliding, paragliding, sailplaning, speleology, parkour, mountain cycling, rowing, motorsports, baseball, sailing, martial arts, carting, kite surfing (kiteboarding), rugby, sandboarding, surfing, wind surfing, water skiing, horse riding, speed-skating, biathlon, bob-sleigh, figure-skating, cross-country skiing, ice-hockey, Alpine skiing, free riding, luge, field hockey, skeleton, slalom, rides with snow motorcycles, snowboard, shorttrack, and other similar high-risk sports and activities regardless whether as an individual or organised lesson, training, competition, or any other time spending;

3.3.9. when the Insured does professional sports aimed at reaching the sports results through participation in competitions, games, or training regardless whether or not it is a source of income of the Insured;

3.3.10. when the Insured does not comply with laws and regulations effective in the territory of his/her location;

3.3.11. when the Insured is carelessness and does not perform all the necessary actions to prevent and reduce possible losses.

3.4. Unless specially indicated in the Insurance policy or unless the parties have specially agreed thereon, the Insurance case shall not be and the Insurance indemnity shall not be paid when losses have been incurred doing a paid or voluntary job that includes physical load or effort.

3.5. The Insurance case shall not be and the Insurance indemnity shall not be paid:

3.5.1. for losses in relation to inability to work, unearned profit, moral damage;

3.5.2. when the Insured at the moment of occurrence of an Insurance case has no or has invalid visa or residence permit, or permanent residence permit;

3.5.3. for losses that in compliance with effective laws and regulations are foreseen to be covered by any type of mandatory insurance;

3.5.4. when the Insured has not kept and cannot submit the paid receipts and other documents that prove the fact of an event and loss amount;

3.5.5. when the Insured has not fulfilled any of the duties indicated in Paragraph 5 therein or has intentionally provided false information;

3.5.6. when the Insured has not claimed the Insurance indemnity for the costs covered by him/her in 30 working days after the expiration of the Policy.

SECTION 3. GENERAL PROVISIONS

4. SUM INSURED

4.1. Sum insured shall be the maximum amount of money indicated in the Insurance agreement the Insurer might be obliged to pay to one Insured upon occurrence of an Insurance case.

4.2. The total due amount of the Insurance indemnity to one person for one or several Insurance cases that have taken place during validity of the Insurance policy may not exceed the Sum insured.

4.3. After payment of the Insurance indemnity, the Insurance agreement shall remain in force and the Sum insured of the particular Insured risk shall be reduced by the amount of the paid Insurance indemnity.

5. OBLIGATIONS OF THE POLICY HOLDER AND INSURED

5.1. The Policy holder shall be obliged to inform the Insured that he/she is insured and present him/her provisions of the Insurance agreement. Otherwise the Policy holder shall be liable for consequences of non-provision of information.

5.2. Upon signing the Insurance agreement, the Policy holder and Insured shall be obliged to provide precise and true information to the Insurer that is significant as for assessing the possibility of occurrence of the Insured risk and that is significant when concluding the Insurance agreement and during validity thereof.

5.3. Inform the Insurer about other effective Insurance agreement referring to the same Insured risk.

5.4. Ensure an opportunity to the Insurer or its authorised representative to establish and assess causes, circumstances, and loss amount of an Insurance case. If necessary, the Insured shall be obliged to authorise the Insurer to get acquainted with the provided information, including medical documentation and in case of a necessity request additional documents and invite an expert commission. The Insured shall agree to an expertise to the expert doctor chosen by the Insurer for checking the health condition in relation to an Insurance case.

5.5. Upon occurrence of an Insurance case, to carry out all possible and reasonable measures to reduce to the possible extent the loss amount and avoid extra costs.

5.6. Upon occurrence of sudden disease or an accident, when the Insured needs Emergency medical care, he/she shall be obliged to promptly in 24 hours turn to a qualified medical practitioner and receive the needed medical care.

5.7. Promptly, as soon as possible, to inform the Insurer or its representative about occurrence of an Insured risk.

5.8. As soon as possible, but not later than in 30 working days after validity of the Policy, to inform the Insurer about costs paid by the Insured itself and/or losses that have been incurred in the result of occurrence of the Insured risk, as well as submit documents to the

Insurer approving occurrence of the Insured risk, conditions, and loss amount thereof, as well as other documents requested by the Insurer.

6. DOCUMENTS TO BE SUBMITTED TO RECEIVE THE INSURANCE INDEMNITY

6.1. A person who claims receipt of the Insurance indemnity shall submit the following documents to the Insurer for the latter to establish whether an Insurance case has occurred and evaluate the loss amount:
6.1.2. Insurance indemnity claim;
6.1.3. a visa or residence permit – after a request of the Insurer;
6.1.4. all original copies of receipts or invoices indicating details of the service receiver (name, surname, birth date) and service provider (name, registration number, bank details), precise title and amount of the service provided, start and end data of service provision, as well as a detailed list of expenses;
6.1.5. a statement of a medical establishment approving the case of an accident or disease indicating a full diagnosis, treatment, examination results, who confirmed the diagnosis, and other treatment services received in relation to the Insurance case; in a case of repatriation – an opinion of a doctor on medically reasoned and necessary repatriation;
6.1.6. a document that approves rights of the Insurance indemnity receiver to receive the Insurance indemnity – birth certificate, passport, power of attorney certified by a notary, decision of an orphans' court or parish court;
6.1.7. in case of death of the Insured – death certificate presenting the original copy;
6.1.8. other documents requested by the Insurer to establish reason and amount of the Insurance indemnity.

7. INSURANCE INDEMNITY

7.1. Upon occurrence of an Insurance case, the Insured or his/her representative shall at first pay from the personal assets for the services received.
7.2. The Insurer shall make a decision whether an accident is considered to be an Insurance case and shall make a decision about payment or refusal to pay the Insurance indemnity not later than in 30 working day after the day when all the necessary documents – written Insurance indemnity application, statements of the relevant pubic authorities, documents that approve the loss amount, statements, powers of attorney, a.o. – have been received and shall send its decision to the Policy holder, Insured, or Beneficiary. Should the Insured due to objective reasons fail to observe this term, the Insurer may prolong the term for up to 6 months as of the day when an application on occurrence of an Insurance case has been received giving a written notice to the person who is entitled to receive the Insurance indemnity.
7.3. The Insurer, making a decision on payment of the Insurance indemnity, shall calculate it in compliance with provisions of the Insurance agreement and Insured risks with regard to a compensation principle, compensating the documentary proved and reasonable costs of the Insured.
7.4. Should in relation to an Insurance case an administrative matter or criminal proceeding is initiated against the Policy holder, Insured, or the person who is entitled to receive the Insurance indemnity, the Insurer shall make a decision on payment of the Insurance indemnity after a court judgement or decision enters into force and is submitted to the Insurer.
7.5. Should the Policy holder fail to pay all Insurance premium by the moment when the Insurance indemnity is paid, the Insurer shall be entitled to deduct or request to pay the unpaid part of the Insurance premium regardless whether the term of paying the Insurance premium has started.
7.6. In case of death of the Insured, the Insurer shall be entitled to request a post-mortem examination covering the costs thereof, except for a case when another person in compliance with laws and regulations is obliged to pay such costs.
7.7. The Insurer shall pay the Insurance indemnity to the Insured, his/her authorised person, or other person who is entitled to receive the Insurance indemnity.
7.8. The Insurer shall apply deductible per each Insurance case from the Insurance indemnity when this is stipulated in the Insurance agreement.
7.9. The Insurer before a full loss calculation may pay a part of the Insurance indemnity in the amount that is not disputed by any party.
7.10. The Insurer shall pay the Insurance indemnity in 5 working days after making a decision about the Insurance indemnity.
7.11. The Insurance agreement wherewith the Insurer pays the Insurance indemnity shall remain valid until the term indicated in the Policy considering the Sum insured to a particular risk reduced by the amount of the paid Insurance indemnity indicated in the Insurance agreement.
7.12. At the moment the Insured receives the Insurance indemnity, he/she shall transfer to the Insurer his/her rights to demand against the person who is responsible for losses in the amount of the paid Insurance indemnity.

8. CONCLUSION AND VALIDITY OF THE INSURANCE AGREEMENT

8.1. The Insurance agreement shall be concluded based on information provided by the Policy holder and Insured to the Insurer. The Insurer shall summarise information provided by the Policy holder and reflect it in the Insurance policy.
8.2. The Insurance agreement may be concluded in person or using distant means of sending and transmission (distant communication means). By distant communication means, Distant insurance agreement shall be concluded.
8.3. Upon conclusion of the Insurance agreement, the Insurer may issue an Insurance policy with a signature of a representative of the Insurer or send a print-out of the Insurance policy prepared electronically by the Insurer's data system.
8.4. The Policy holder shall approve conclusion of the Insurance agreement (including a distant insurance agreement) and genuineness of information indicated therein by paying the Insurance premium or first part thereof, if payment of the Insurance premium by instalments has been defined, under the procedure, term, and amount indicated in the Insurance policy or by signing the Insurance agreement electronically or manually.
8.5. The Insurance agreement shall enter into force on the date and time that is indicated in the Insurance policy when the Insurance premium or the first part (when payment of the Insurance premium has been defined by instalments) thereof has been paid under the procedure, term, and amount indicated in the Insurance policy.
8.6. The Insurance agreement shall be valid only as for the Insured risks and in the Insurance territory indicated in the Insurance agreement.

8.7. The Insurance agreement shall be concluded in Latvian unless the Insurer and Policy holder has agreed in written on conclusion of the Insurance agreement in a foreign language as well. Should Latvian and a foreign language are used in the insurance agreement, its Latvian text shall be the prevailing when contradictions appear.

9. INSURANCE PREMIUM AND PAYMENT PROCEDURE THEREOF

9.1. The Policy holder shall be obliged to pay the Insurance premium under the procedure, terms, and amount indicated in the Insurance policy or invoice regardless whether the invoice has been issued or sent for payment of the Insurance premium or a part thereof.

9.2. Should the Insurer fail to receive payment of the Insurance premium or its first part in the amount and/or term indicated in the Insurance policy, the Insurance agreement shall not enter into force and the Insurer shall have rights to repay the received Insurance premium or its first part. Should this be the case, the Insurer in 10 working days as of the day of paying the Insurance premium or its first part shall return the paid Insurance premium or its first part to the Policy holder and submit a request to the Policy holder to inform the Insurer about type of returning the Insurance premium or its first part.

9.3. Should the Insurer, in the term set in Paragraph 9.2, fail to return the Insurance premium or its first part or to submit a request mentioned in Paragraph 9.2 to the Policy holder, the Insurance agreement shall enter into force as of the date indicated in the Insurance policy.

9.4. Should payment of the Insurance premium or its first part be made after the term indicated in the Insurance policy and/or has not been made in the full amount and an Insurance case has occurred by the day of paying the Insurance premium or the first part thereof, it shall be deemed that the Insurance agreement has not entered into force and the Insurer shall be obliged to notify the Policy holder on invalidity of this agreement and return the received Insurance premium or the first part thereof in 10 working days as of the day of paying the Insurance premium or the first part thereof or submit a request to the Policy holder to inform the Insurer about type of returning the Insurance premium or the first part thereof.

9.5. Should it be stated, when concluding the Insurance agreement, that the Insurance premium shall be paid by instalments and the Insurer has not received the current payment of the Insurance premium in the amount and/or term indicated in the Insurance policy, the Insurer shall sent a written notice to the Policy holder about partial and/or delayed payment of a part of the Insurance premium requesting to pay the part of the Insurance premium in compliance with provisions of the Insurance agreement, and indicating the amount and term of the unpaid amount of the part of the Insurance premium and possible consequences of non-payment thereof.

9.6. Should the Policy holder fail to pay the part of the Insurance premium in compliance with the term and/or amount indicated in the notification, which is mentioned in Paragraph 9.5, the Insurance agreement shall be terminated.

9.7. Payment of the Insurance premium shall be made in the currency that is defined for the Insurance premium in the Insurance policy or in another currency indicated in the invoice. When paying the Insurance premium in another currency, the difference in the result of currency conversion or in relation to other costs of the bank services shall be covered by the payer.

9.8. Should the payment of the Insurance premium is performed as a transfer, the date of paying the Insurance premium shall be the date when the Insurer or insurance agent, which is authorised to collect Insurance premiums for the concluded Insurance agreement on behalf of the Insurer, has received the payment in the bank account.

10. EARLY TERMINATION OF THE AGREEMENT AND RETURN OF THE INSURANCE PREMIUM

10.1. The Policy holder and Insurer may terminate the Insurance agreement before the term in the cases and under the procedure stipulated in Law on Insurance Contracts.

10.2. The Insurance agreement may be terminated before the term of the insurance agreement upon mutual agreement of the Policy holder and Insurer.

10.3. Upon early termination of the Insurance agreement, the Insurer shall return the part of the Insurance premium to the Policy holder and the amount thereof shall be defined by deducting the paid share of the Insurance premium for the period of using the Insurance agreement, as well as provable Insurer's costs in relation to the Insurance agreement's conclusion not exceeding 20% of the Insurance premium if the Insurance indemnity has not been paid out and/or Insurance case has not been reported during validity of the Insurance agreement.

10.4. When during validity of the Insurance agreement Insurance indemnity has been paid and the paid Insurance indemnity is smaller than the difference between the paid Insurance premium and the share of the Insurance premium for the period of use of the Insurance agreement, the Insurer shall return to the Policy holder the share of the Insurance premium, the amount of which is defined by deducting the Insurance indemnity, the share of the Insurance premium for the period of use of the Insurance agreement, and provable costs of the Insurer in relation to conclusion of the Insurance agreement not exceeding 25% of the Insurance premium from the paid Insurance premium.

10.5. When during validity of the Insurance agreement the Insurer has paid Insurance indemnity and the paid indemnity exceeds the share of the Insurance premium to be returned, the Insurer shall not return the Insurance premium to the Policy holder.

10.6. The procedure mentioned in Paragraphs 10.4 and 10.5 shall refer also to cases when the Insurance case has been claimed and the foreseen amount of the Insurance indemnity has been calculated but the Insurance indemnity has not been paid yet.

10.7. Should an Insurance case is claimed in compliance with the Insurance agreement to be early terminated, the Insurance policy may not be terminated before the day of calculating the Insurance indemnity, unless otherwise agreed on with the Insurer.

10.8. The Insurer, in 15 days from the day of sending a relevant written notice, may unilaterally terminate the Insurance agreement if possibility of occurrence of the Insured risk has increased during validity of the Insurance agreement and the Insurer can prove that it would not have concluded the Insurance agreement if knowing about such increase and the Policy holder has not approved amendments/supplements to the Insurance agreement initiated by the Insurer.

10.9. Upon conclusion of a distant insurance agreement, the Policy holder shall have withdrawal rights and rights to unilaterally step back from this Insurance agreement giving a written notification to the Insurer in 14 working days after the day of concluding this Insurance agreement. Should this be the case, the Insurance agreement shall lose its effect on

the day of sending the withdrawal notification. The Insurer shall return the part of the insurance premium with its amount defined by deducting the share that corresponds to the share of the Insurance premium for actual time of validity of the Insurance agreement.

11. MISCELLANEOUS

11.1. The Insurance agreement may be amended by a written agreement between the Policy holder and Insurer.

11.2. The Insurer may not turn to children, parents, or spouse of the Insured with recourse, except for the cases when an Insurance case has been initiated by malice or gross negligence.

11.3. Claims or complaints of the Policy holder or Insured person submitted in written shall be examined by the Insurer providing a written answer in 30 days as of receiving the claim or complaint.

11.4. The Policy holder shall agree that the Insurer as a system manager and operator of personal data processes the Policy holder's personal data (including sensitive data and personal identification (classification) codes) with an aim to ensure fulfilment of the Insurance agreement or provide information to the Policy holder about services rendered by the Insurer and its cooperation partners and/or transfer them for processing to the third person with an aim to ensure fulfilment of the Insurance agreement or to provide the Insurer's defined information about its services to the Policy holder.

11.5. The Insurer shall not disclose information about the Policy holder and Insured to the third persons, except for the cases stipulated in laws and regulations of the Republic of Latvia. However the Insurer, for provision of efficiency of its commercial activity, shall be entitled to exchange information with other Insurers about the Insured and Policy holder.

11.6. During validity of the Insurance agreement, the Insurer shall contact the Insured and Policy holder in Latvian, as well as respond to queries expressed in Latvian or any other language that is known to both parties.

11.7. As for regulation of relations deriving from the Insurance agreement, Law on Insurance Contracts, Civil Law, and other laws and regulations of the Republic of Latvia shall be applied.

11.8. All disputes in relation to the Insurance agreement shall be settled through negotiations. Should settlement fail to be reached, the dispute shall be transferred for settlement in a court of the Republic of Latvia in compliance with the procedure set in laws and regulations of the Republic of Latvia.

Deividas Raipa,
Chairman of the Board

Tomasz Rowicki,
Member of the Board