CIG PANNÓNIA
BIZTOSÍTÓ

PANNÓNIA ELIXÍR

group health insurance

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GENERAL FEE-FOR-SERVICE HEALTH INSURANCE TERMS AND CONDITIONS

1) General provisions

a) These Terms and Conditions contain the provisions which, unless otherwise stated, are applicable to the fee-for-service health insurance contracts of CIG Pannónia Életbiztosító Nyrt. (seat: 1097 Budapest, Könyves Kálmán krt. 11. B épület, hereinafter referred to as "Insurer") and to the parts of its insurance contracts containing such risks (hereinafter referred to as "insurance"), provided that the contract was concluded with reference to these Terms and Conditions.
b) The language of the contract is Hungarian.

2) Insured Event

a) An insured event is the use of a medical service which becomes necessary and medically justified due to an illness, pathological condition or accident of the Insured Party during the period of risk coverage applicable to him, not related to any precedent compared to the beginning of the period of risk coverage. An illness, accident or medical condition without a precedent is defined as an illness, accident or pathological condition that is not causally related to the illness, accident, pathological condition or established permanent impairment that existed before the period of risk coverage or was diagnosed and requires treatment.
b) The insured event also covers the use of health services and counselling aimed at preserving the health of the Insured Party and prevention.

3) Definitions

The following terms shall have the meaning as used in these terms and conditions and any use of such terms in other fields or contexts which may have a different meaning shall not apply to contracts under these terms and conditions.

a) **Outpatient Surgery:** surgical or other specialised treatments and interventions that can be carried out without anaesthesia, after which the patient can be discharged home immediately without specialist supervision and observation, and which can be carried out in the framework of out-patient care under the legislation in force, and which are not considered as same-day surgical care.
b) **Accident:** a single and sudden external impact (mechanical, electrical or chemical) on the human body, independent of the Insured Party's will, which results in injury, poisoning or other bodily harm, which shows immediate clinical, anatomical and functional signs of impairment and requires acute (within 3 days) specialist medical attention. The injury (damage) sustained can be shown to be directly causally related to the accident and to cause death, temporary or permanent physical impairment within one year.

c) **Intervention:** any preventive, diagnostic, therapeutic or other physical, chemical, biological procedure that induces or may induce a change in the patient's body.
d) **Illness**: an abnormal physical or mental condition in the health of the Insured Party, which is not considered to be accidental and which has objective symptoms, according to the current generally accepted view of medical science.
e) **Patient Transport:** the transport of the Insured Party within the national borders, without the need for ambulance supervision, due to complaints arising from an illness or accident within the period of risk coverage, if the Insured Party becomes disabled or cannot be transported to a health care institution by other means.
f) **Insurance Policy:** The insurance policies containing the insured events and the Insurer's services, chosen by the Policyholder, which are set out in the offer documents. The Insurance Policy chosen by the Policyholder and indicated in the offer documents for a given Insured Party may only be changed (policy change) on the anniversary date of the insurance year.
g) **Insurer:** the legal entity who, against payment of the premium, bears the insurance risk and provides health insurance services in the cases, in the manner and to the extent specified in these conditions.
h) **Insured Party:** the natural person whom the Policyholder designates as a member of an insured group determined by it. The Insured Party is over 18 years of age at the start of the risk coverage but under 70 years of age. The age of entry for a given Insured Party is the difference between the year in which the risk coverage commenced and the Insured Party's year of birth. The current age of the Insured Party is calculated from the age of entry: it is increased by one for each anniversary of the insurance year.
i) **Diagnostic Examination:** a medical procedure aimed at finding the cause of the Insured Party's complaint, clarifying his condition, confirming or excluding the existence of a disease, but not, in itself, aimed at changing the condition.
j) **Dietetic advice:** individualised nutritional and lifestyle advice from a qualified professional.
k) **Medical documentation:** Information about the Insured Party's medical examination and treatment is included in the medical records. The medical documentation must be kept in such a way that it reflects the process of care in a realistic manner. The medical documentation must include:
   - the personal identification data of the insured party,
   - the name, address and contact details of the person to be notified in the case of an Insured Party with legal capacity, or the name, address and contact details of the legal representative in the case of an Insured Party under guardianship,
   - medical precedents, medical history,
   - the result of the first examination,
   - the results of the tests forming the basis of the diagnosis and treatment plan and the date on which the tests were carried out,
   - the name of the disease justifying the treatment, the underlying disease, concomitant diseases and complications, other diseases not directly justifying the treatment and risk factors,
   - the duration and outcome of the interventions carried out,
   - any drug and other therapy and its results,
   - information about the Insured Party's hypersensitivity to medicines,
   - the name of the health professional making the entry and the date of entry,
   - the recording of the content of the information provided to the Insured Party or to any other person entitled to receive the information,
   - the fact of consent or refusal and the date thereof,

- any other data and facts which may have an influence on the insured party's recovery.

It must be kept as part of the medical record:

- the results of each examination,
- documents generated during treatment and consultation,
- nursing records,
- records of diagnostic imaging procedures and tissue samples taken from the insured party's body and their histological results.
- a written summary report (discharge report) must be drawn up at the end of a coherent process of care consisting of several activities or after an inpatient stay and given to the insured party.

l) **Healthcare:** the totality of health care activities related to the insured party's particular state of health.

m) **Healthcare Service:** the totality of health care activities that can be performed under an operating licence issued by a Hungarian state health care administration body, which is intended to examine and treat the Insured Party in order to preserve the health of the individual, prevent, detect, diagnose, treat, prevent danger to life, improve the condition resulting from the illness or prevent further deterioration of the condition, care, nursing care, reduction of pain and suffering, and the processing of the Insured Party's medical records for the above purposes, including activities relating to medicines, medical aids and medical care in accordance with specific legislation.

n) **Healthcare Service Provider:** any individual health care business, legal entity or unincorporated organisation entitled to provide healthcare services (on the basis of an operating licence issued by a Hungarian body or authority), regardless of the form of ownership or the controlling entity.

o) **Care Organiser:** The legal person or unincorporated organisation which, under a separate contract with the Insurer, is entitled to organise the Healthcare Services to which the Insured Party is entitled, and to provide the service to the Insured Party. With regard to this condition, the Insurer's Care Organiser partner is Teladoc Hungary Kft. (seat: 1092 Budapest, Köztelek utca 6. I. épület, 2. emelet.).

p) **Same-day surgery:** a planned surgical intervention as defined by law (at the time of entry into force of these conditions, Decree 16/2002 (XII. 12.) of the Ministry of Health, Social and Family Affairs), which is justified by medical opinion and professional rules and can be performed at the choice of the Insured Party using the care and on the basis of the results of the examination, and after such intervention the Insured Party can leave the institution within 24 hours of admission to the institution, after observation.

q) **Physiotherapy:** Medical treatment by a qualified health professional, in accordance with the legislation in force, using physical energy, heat, electrical energy or mechanical forces.

r) **Inpatient Care:** healthcare provided during the Insured Party's continuous hospital stay, which may be same-day surgery or multi-day care.

s) **Care:** Regular, permanent or intermittent outpatient and/or inpatient, laboratory or diagnostic care required as a result of the Insured Party's illness (usually a chronic illness), where the reason for the care is not an acute deterioration or a new symptom or abnormality.

t) **Physiotherapy:** A movement therapy programme, designed by a qualified physiotherapist, which uses an appropriately matched stimulus sequence to produce functional improvement.

u) **Medication, bandage, medical aids:** drugs, supplies and devices that are necessary and medically justified for the restoration of the Insured Party's health and are recognised and registered as such in Hungary. The materials and devices used for vision and hearing aids and dental care are not considered medical aids under this Condition.

v) **Repatriation:** a one-off repatriation to the country of permanent residence of the Insured Party due to complaints arising from an illness or accident that occurred within the period of risk coverage (and which is medically justified by the Insured Party's state of health).

w) **Home Visit:** medical treatment at the home of the Insured Party due to acute symptoms or sudden deterioration of health, on the basis of the indication of the Care Organiser's doctor and organised by the Care Organiser, where it is assumed, on the basis of the notification and the answers to the questions asked, that the indicated complaint may be solved at the Insured Party's home without the involvement of a specialist and without the need for immediate medical intervention (the notification does not indicate that the Insured Party's condition requires emergency care or immediate ambulance transport or that the complaint is not related to pregnancy or childbirth).

x) **Outpatient Care:** one-off or occasional medical care provided by a specialist doctor on the basis of a referral from a doctor providing ongoing care for the Insured Party or on the basis of an application from the Insured Party.

y) **Beneficiary:** the insured party is entitled to all the services of the insurer.

z) **Attending physician:** the physician or physicians who determine the plan of examination and treatment for the insured party's illness or condition and who carry out the interventions in connection with these, and who are responsible for the treatment of the insured party.

aa) **Designated Healthcare Service Provider:** healthcare service provider providing primary care (in English) of a general practitioner nature, to be specified in the offer documentation.

bb) **Hospital:** In Hungary, an inpatient care facility licensed by the professional inspectorates, under permanent medical management and supervision and with an appropriate institutional code. Sanatoria, day hospitals, psychiatric institutions, rehabilitation institutions, spas, mental health and care institutions, alcohol and drug rehabilitation institutions, hospices, nursing homes, chronic inpatient care institutions, geriatric institutions, elderly homes and departments of hospitals providing such services are not considered hospitals.

cc) **Laboratory Testing:** physical, chemical, biological methods used to examine human tissue samples and biological products under laboratory conditions to determine the composition, biological activity and contamination of samples.

dd) **Limit:** the upper limit on the amount of the Insurer's service obligation (limit for the insurance period), above which the Insurer is not obliged to provide any additional service to the Insured Party in relation to the Insured Party's health care during the insurance period for the named types of services. The limits applicable to a given contract are set out in the offer documentation.

ee) **Second Medical Opinion:** a remotely provided medical opinion by a renowned international medical expert with a high level of professional experience in the relevant field, based on a medical question raised by the Insured Party to the Care Organiser concerning the serious illness of the Insured Party.

ff) **Surgery:** for the purposes of this insurance, any surgical intervention performed by a doctor in accordance with the current medical rules of practice, for the purpose of treatment and for which the doctor and the institution performing the intervention have the necessary valid and current licences.

gg) **Excess:** the amount specified in the offer documents which the Insured Party is obliged to pay for a specific insured event. The excess is shown per insured event and per Insured Party, if applied by the Insurer.

hh) **Psychiatric Consultation**: mental health assessment and treatment by a professional with appropriate medical training.

ii) **Psychological Counselling:** counselling provided by a qualified professional.

jj) **Medical Specialist:** Doctors with valid specialist examination and licence to practise, excluding doctors with a specialist examination in general medicine, occupational health medicine and disaster medicine.

kk) **Emergency Medical Treatment:** a change in health which, in the absence of immediate medical treatment, would put the Insured Party's life in immediate danger or cause serious or permanent damage to health. Life-threatening conditions and illnesses covered by the scope of emergency need are detailed in the Annex to Decree 52/2006 (XII. 28.) of the Ministry of Health (Section C.2.2 v).

ll) **Emergency Dental Care:** dental care that may be provided in the event of an accident or sudden deterioration in the condition of the Insured Party.

mm) **Policyholder:** a natural or legal person or an unincorporated entity (hereinafter referred to as "person") with an interest in protecting the health of the groups to be insured, who concludes the insurance contract and makes valid declarations, provides information to the Insured Parties and pays the premiums during the period of insurance.

nn) **Screening Test:** any test aimed at the early detection of a possible existing disease or pre-existing condition of an asymptomatic Insured Party.

oo) **Territorial Scope:** The Insurer's risk coverage extending to the territory of Hungary and to health care and medical services available in Hungary.

4) Duration of the contract, renewal date and period of insurance

a) The insurance shall be concluded for a fixed or indefinite period, as mutually agreed between the Policyholder and the Insurer.

b) The renewal date is the same day of each year as the day on which the initial recognition date starts. If there is no such day in a year, it is the last day of the month concerned.

c) The insurance period is 1 year between each renewal date within the duration of the insurance. On the basis of a mutual agreement between the Policyholder and the Insurer for a fixed term, the insurance period may be shorter than 1 year.

d) An insurance contract concluded under these terms and conditions for a fixed term of one year shall be automatically renewed for a further one-year period on unchanged terms if neither party informs the other party in writing no later than 30 days before the expiry of the term that it does not wish the contract to be automatically renewed. This rule should also be duly applied when the extension expires.

5) Conclusion of the contract

a) An insurance contract with reference to these terms and conditions shall be concluded upon acceptance of the Policyholder's offer by the Insurer in writing.

b) The insurance is also concluded if the Insurer does not respond to the offer within 15 days of its receipt, or within 60 days if a health declaration or medical examination is required for the assessment of the offer, provided that the offer was made in accordance with the offer form and the tariffs provided by the Insurer, having received the information required by law and on the content of the legal relationship. In this case, the insurance contract shall be concluded on the 16th day after the date of receipt of the offer by the Insurer or the Insurer's representative, or on the 61st day if a health declaration or medical examination is required for the assessment of the offer, in accordance with the contents of the offer and with retroactive effect to the date on which the insurance offer was received by the Insurer or the Insurer's representative. If the contract was not concluded in writing, the Insurer is obliged to issue a

document (insurance policy) proving the insurance cover. If a contract concluded without the express declaration of the Insurer differs in material respects from the general terms and conditions of the Insurer, the Insurer may propose that the contract be amended in accordance with the general terms and conditions within 15 days of the conclusion of the contract. If the Policyholder does not accept the proposal or does not respond to it within 15 days, the Insurer may terminate the contract in writing within 15 days of the rejection or receipt of the amendment proposal with a 30 days notice.

c) **The applicant is bound by its offer for 15 days from the date of submission of the offer.**
d) The Insurer is not obliged to give reasons for any rejection of the offer.
e) After the conclusion of the insurance contract, within 30 days of the conclusion of the contract, the Insurer shall inform the Policyholder of the conclusion of the insurance contract in a verifiable and identifiable manner, in the official language of the Member State of the place of commitment or, if so agreed, in another language at the express request of the Policyholder.
f) If the document proving the cover differs from the Policyholder's offer and the Policyholder does not object to the difference without delay (within 15 days) after receipt of the document, the contract shall be concluded with the content of the document proving the cover. This provision shall apply to material deviations if the Insurer has drawn the Policyholder's attention to the deviation in writing at the time of handover of the document proving the cover. If no notice is made, the contract will be concluded in accordance with the content of the offer.
g) The Insurer has the right to ask questions about the Insured Party's state of health, leisure activities and occupation (hereinafter referred to as the "health declaration") and to require a medical examination to assess the risk. The client may obtain the results of the tests carried out from the Healthcare Service Provider in accordance with Act CLIV of 1997 on Health Care.
h) The Insurer will charge the full cost of the medical examination to the Policyholder and will reimburse the Policyholder the value of the premium paid less the cost of the medical examination if the Policyholder, after the medical examination necessary for the assessment of the offer:
    - withdraws from the conclusion of the contract,
    - objects without delay (within 15 days) after receipt of the policy to a contract concluded with a content different from that of the offer,
    - fails to remedy the deficiencies in the offer despite the Insurer's request and the Insurer rejects the offer.
i) If an insured event should occur during the risk assessment, the Insurer may only exercise the right of refusal if it has expressly drawn this possibility to attention on the offer or declaration of the establishment of additional cover, and it is obvious from the nature of the insurance cover requested or the circumstances of the risk coverage that an individual assessment of the risk is necessary for the acceptance of the offer or the declaration of the establishment of additional cover.

6) Initial recognition date and joining of Insured Parties

e) The risk coverage of the Insurer depends on the date of the Insured Party's entry into the insurance contract:

- for the Insured Persons named at the time of the conclusion of the insurance contract, it shall begin at 0:00 on the first day of the month following the signing of the offer, provided that the contract has been concluded or is subsequently concluded and the first instalment of the premium has been paid to the Insurer or the parties have agreed to defer payment of the premium. By mutual agreement, the parties may agree to a later initial recognition

date. The amount paid before the conclusion of the contract will be treated by the Insurer free of interest until the date indicated in the insurance contract, but the payment of this amount does not constitute the beginning of the risk coverage.

- In the case of new insured persons entering the insurance contract during the term, the Insurer's coverage shall commence at 0:00 on the first day of the month following the date of the information sent by the Policyholder to the Insurer, provided that the premium for their person has been paid to the Insurer or a deferment of payment of the premium has been agreed.

f) Unless otherwise agreed by the Parties, by completing the Policyholder Declaration, each Insured Party explicitly consents to the extension of the scope of the fee-for-service group health insurance contract between the Policyholder and the Insurer, as well as to the processing of their personal health data and the release of the institutions and persons handling their health data from the obligation of medical confidentiality. The Policyholder must fill in the declaration accurately and completely. In the absence of a completed and signed declaration, the Insurer will not provide any service. The Insured Party may withdraw his consent to become insured at any time in writing.

7) Disclosure obligation

a) When concluding the insurance contract, the Policyholder and the Insured Party are obliged to disclose to the Insurer in writing all circumstances which are relevant to the taking out of the insurance and which they knew or ought to have known.
b) The written answers given by the insurer to written questions, which shall be truthful, shall fulfil the obligation of the policyholder and the insured party to provide information. Failure to answer questions does not in itself constitute a breach of the duty of disclosure.
c) The Policyholder and the Insured Party shall enable the insurer to check the data and circumstances relevant to the insurance. The Insurer is entitled to verify the information provided.
d) In the event of a breach of the duty to disclose, the Insurer's obligation shall not arise unless the Policyholder or the Insured Party proves that the concealed or unreported circumstance was known to the Insurer at the time of conclusion of the contract or did not contribute to the occurrence of the insured event.
e) Notwithstanding the breach of the duty of disclosure, the Insurer's obligation shall arise if 5 years have already elapsed from the conclusion of the contract or the entry of the additional Insured Party(ies) during the term of the contract until the occurrence of the insured event in relation to the Insured Parties.
f) If the contract applies to several persons and the breach of the duty of disclosure arises only in relation to some of them, the Insurer may not invoke the breach of the duty of disclosure in relation to the other persons.
g) The obligation to disclose is incumbent on both the Insured Party(ies) and the Policyholder. Neither of them may rely on a circumstance which either of them has failed to communicate to the insurer, although they should have known about it and should have been obliged to do so.
h) If the Insurer becomes aware of material circumstances affecting the contract after the conclusion of the contract and these circumstances result in a significant increase in the insurance risk, it may propose an amendment to the contract within 15 days of becoming aware of the circumstances or terminate the contract in writing with a 30 days notice. If the Policyholder does not accept the proposed amendment or does not respond to it within 15

days of receipt, the contract shall be terminated on the 30th day following the date of notification of the proposed amendment, provided that the Insurer has drawn the Policyholder's attention to this consequence when making the proposed amendment. If the contract covers more than one person at the same time and the insurance risk increases significantly in relation to only some of them, the Insurer may not exercise the rights provided for in this Section in relation to the other persons.

i) If the Insurer becomes aware after the conclusion of the contract or the entry of the additional Insured Party(ies) during the term of the contract of a material circumstance that existed at the time of the conclusion of the contract or the entry of the additional Insured Party(ies), the Insurer may exercise the rights arising therefrom during the first 5 years of the term of the contract or the first 5 years after the entry of the additional Insured Party(ies).

8) Data provision

a) The Policyholder may amend the List of Insured Parties on a monthly basis.
b) The information contained in the notification will take effect on the first day of the month following the month in which the notification is made, i.e. it is not possible to notify an Insured Party's entry or exit for the current month.
c) The detailed rules for the provision of data containing the Insured Party's details to be sent by the Policyholder to the Insurer are set out in the Offer Documentation.

9) Obligation to prevent and mitigate damages

a) The insured party must act in a way that is normally expected in the circumstances in order to prevent damage.
b) The insured party must mitigate the damage in accordance with the insurer's rules and instructions or, failing these, in accordance with the requirements of what is normally expected under the circumstances. Accordingly, they must seek medical assistance immediately after the first medical diagnosis of an illness or after an accident and continue medical treatment until the end of the medical course of treatments. Furthermore, they must provide appropriate care and endeavour to prevent further insured events as far as possible and to mitigate the damage suffered. If the insured party fails to fulfil the obligation to mitigate the damage and the insured party's condition has aggravated as a result, the insurer shall be discharged from the obligation to pay benefits arising from such aggravation. For the purposes of applying the rules on the obligation to mitigate the damage, the failure of the insured party to consent to medical treatment in exercise of his statutory right of disposal shall not be considered to be a reason for the insurer's exemption.

10) Providing the insurance

a) On the basis of the insurance contract concluded between the Policyholder and the Insurer, the Insurer shall provide the Insured Party with the services specified in the Special Terms and Conditions, depending on the content of the insurance policy(ies) applied for.

11) Performance by the Insurer, documents required for performance

a) The insurer will provide the services under the Contract in accordance with the terms and conditions of the Contract in force at the time of the insured event.

b) The insurer shall not be obliged to provide cover if any force majeure (unforeseeable and unavoidable external hindrance beyond the insurer's control) precludes or limits performance – az akadály elhárultáig.

c) Ex-post reimbursement: the Insurer will reimburse the costs of medical treatment, medication, dressings, temporary medical aids, patient transport prepaid by the Insured Party, if reimbursable under the applicable insurance conditions. Details of the ex-post reimbursement are set out in the Special Terms and Conditions and in the Offer Documentation.

d) Claims for reimbursement of medical care, medicines, dressings, temporary medical aids, patient transport prepaid by the Insured Party (ex-post reimbursement) must be submitted within fifteen (15) days of the date of the invoice.

e) In the case of coverage for a sum insured, the insured event must be reported to the Insurer in person or in writing within 15 working days of its occurrence, the necessary information must be provided and it must be possible to verify the content of the report and the information provided. If such notification is not made and material circumstances become impossible to ascertain, the Insurer shall not be liable. The Insurer may grant an extension for the submission of the documents required for performance on a case-by-case basis.

f) The Insurer shall pay the monetary services within 15 days of the receipt by the Insurer of the last document necessary for the assessment of the claim, provided that the legal basis exists. If the documents requested by the Insurer are not submitted despite a request or are submitted incompletely, the Insurer shall assess the service claim on the basis of the available documents after 30 days from the date of the request. The Insurer shall make payments which are delayed due to late submission of the claim or the documents necessary for its fulfilment free of interest.

g) **Depending on the nature of the insured event, the Insurer may request the following documents for the performance of the service:**

- a copy of the Insured Party's medical documents relating to the insured event and medical history (such as GP or occupational health physician's, outpatient and inpatient care records, hospital discharge reports, medical records of surgery, documents proving the use of medication, histopathological examination results, including CT, MRI and X-ray images and their examination results, (specialist) medical referral and/or recommendation for specific treatment);
- documents held by the social security organisation or other person or organisation containing the insured person's data relating to the insured event or the circumstances underlying it;
- any additional declarations which the legislation in force from time to time lays down as conditions for the provision of the service;
- translations of documents in foreign languages;
- in case of ex-post reimbursement, the invoice issued to the name of the Insured Party, copies of all medical documents related to the insured event and a statement (signed and dated) containing the Hungarian (HUF) residential bank account number and the Hungarian postal address provided by the Insured Party,
- in the case of sum insured cover, the service claim form issued by the Insurer,
- a copy of the identity card or other document suitable for identification, address card.

The costs of obtaining the documents included in the list requested by the Insurer shall be borne by the Insured Party.

Where the consent of the data subject is required for the obtaining of a document for reasons of data protection, the obtaining or giving of such consent shall be the obligation of the

Insured Party and the cost of obtaining the documents shall also be borne by the Insured Party.

12) Waiting period

a) The Insurer waives the waiting period for all insurance services.

13) Payment of premium

a) The insurance premium is the consideration for the Insurer's service, the payment of which is the obligation of the Policyholder. The Policyholder may pass on to the Insured Party all or part of the premium paid by the Policyholder.
b) The insurance is subject to regular premium payments.
c) The premium is payable at the frequency and in the currency indicated in the offer.
d) The first premium of the insurance is due at the time of signing the offer, unless the Parties have agreed on a deferred premium payment. All additional premiums are due on the first day of the period to which they apply. The Policyholder is obliged to pay the first premium of the insurance after the first data provision against a pro-forma invoice issued by the Insurer within the payment deadline indicated therein.
e) The premium can only be paid by bank transfer. The premium shall be deemed to have been paid when it has been received in full, with the clearly identifiable Policy, in the account of the Insurer established for this purpose.
f) The Insurer is entitled to the premium for the entire duration of the risk coverage.
g) Paying more than the instalment due does not entitle to any additional service. The Insurer shall treat the premium surplus paid as an interest-free premium advance and offset it against the next premium instalment due.
h) If the Policyholder fails to pay the premium due, the Insurer shall notify the Policyholder in writing of the payment of the premium, setting a 30-day extended deadline from the date of the notice. If the extended deadline expires without result, the contract shall be terminated with retroactive effect to the due date, unless the Insurer enforces the claim for the premium without delay in court. The Insurer's obligation to provide service shall continue until 30 days after the premium due date.
i) The Insurer shall not accept partial payment of the premium; it shall return the partially paid premium to the Policyholder without interest within 15 days of receipt, and shall act in accordance with the rules applicable to non-payment of the premium.
j) The Insurer is entitled to review the premium and adjust it for the insurance period following the insurance renewal date due to changes in the composition of the insured groups, changes in health service fees or unforeseen deterioration in claims experience. The Insurer shall notify the Policyholder of its intention to change the premium no later than 60 days before the insurance renewal date.
k) If the Policyholder fails to make a written statement on the proposed amendment no later than 30 days before the insurance renewal date, the Insurer shall consider the insurance contract with the amended premium rate to be valid. If the Policyholder rejects the proposed amendment in writing no later than 30 days before the insurance renewal date, the insurance contract will terminate on the insurance renewal date.
l) If the Policyholder does not pay the insurance premium to the account of the Insurer in the currency of the contract, the amount shall be transferred to the account of the Insurer in the currency of the contract according to the conditions of the Insurer's bank where the account

is held (MKB Bank Nyrt, hereinafter referred to as “Bank”). The amount so credited shall be considered by the Insurer as a premium paid. **The exchange rate risk or additional costs resulting from incorrect payments shall be borne by the Policyholder.**

m) The Policyholder may pay the premium(s) by individual transfer in HUF to the **HUF bank account number 10300002-10315709-49020021** of the Insurer held at MKB Bank Nyrt., with IBAN code HU37 1030 0002 1031 5709 4902 0021. The international bank identification code of MKB Bank Nyrt. is MKKBHUHB.

n) **If the Policyholder does not wish to pay the premium in the currency of the contract, the Insurer shall set the premium payable as follows in order to mitigate the exchange rate risk arising from this. In the case of a bank transfer, the Policyholder must transfer a premium equal to 105% of the premium due to the account of the Insurer corresponding to the currency of the payment.**
Any remaining exchange rate risk notwithstanding the above shall be borne by the Policyholder.

14) Settlement

a) The contract is an annual settlement contract, unless the Parties agree otherwise, i.e. the Policyholder pays the premium agreed at the beginning of the insurance period (which may vary from one group of insured persons to another) according to the premium payment frequency chosen by the Policyholder during the insurance period.

b) Further detailed rules on the settlement of accounts are set out in the offer documentation.

15) Residual rights, technical interest rate, excess return

a) The contract has no residual rights. There is no possibility to borrow on a policy, to deliver the contract free of charge or to repurchase it.

b) The Insurer has not used a technical interest rate in the calculation of the premium, and the insurance does not provide for refunding any excess return.

16) Exemption of the Insurer

a) The Insurer shall be released from its obligation to provide services if it proves that the damage was caused unlawfully, intentionally or through gross negligence by the Insured Party or a relative living in the same household.

b) If the Insured Party fails to comply with the obligation to recover the damage and therefore his condition has worsened as a result, the Insurer shall be released from the obligation to provide services resulting from such worsening of the condition.

c) Notwithstanding the other provisions of this Contract, this Insurance Contract shall entitle the Insured Party to service or any payment to be made by the Insurer, provided that it does not conflict with any economic, commercial or financial sanction and/or embargo imposed by the United Nations Security Council or the European Union, or any other national law applicable to the parties to this Contract. This provision shall also apply to any economic, commercial or financial sanctions and/or embargoes imposed by the United States of America or any other country, to the extent that they are not inconsistent with the laws of the European Union or Hungary.

d) In the event of exemption by the Insurer, the Policyholder shall not be entitled to any refund of the premium.

17) Risk Exclusions

The Insurer's coverage does not include

a) insured events which are connected with damage caused intentionally by the Insured Party to himself (even if the Insured Party caused the damage while in a state of disturbed consciousness);

b) for insured events arising from: participation in an insurrection, rebellion, riot, act of terrorism, war, act of war, act of hostility by a foreign power, coup or attempted coup against the government, riot, civil war, revolution, demonstration, march, strike, workplace disturbance, border disturbance;

c) insured events that may be associated with the effects of nuclear energy or ionising radiation;

d) insured events that occur in connection with the Insured Party's alcoholic condition (0.8 parts per thousand or higher blood alcohol level), consumption of intoxicants, narcotics or similar substances, addiction to toxic substances due to regular use;

e) care in connection with pregnancy or childbirth, and the consequences of an impairment of health occurring within one year of childbirth (except outpatient care to establish pregnancy), and interventions relating to the care of pregnancy outside the womb;

f) insured events which occur in causal relationship with the Insured Party's driving without a driving licence or other necessary official authorisation;

g) medical treatment which is not intended to diagnose the Insured Party's illness, prevent deterioration in his state of health or restore his health;

h) screening tests (not including annual preventive examinations indicated in the Special Terms and Conditions);

i) care for rehabilitation, sanatorium treatments, spa treatments, diets;

j) dialysis treatment;

k) psychiatric and psychotherapeutic care;

l) non-conventional procedures as defined by law, including acupuncture, naturopathy;

m) treatment provided by alternative medicine, wellness services, physiotherapy, speech therapy, spa treatment, slimming treatments, natural remedies, spa and climatic treatments, health resorts;

n) care for the prescription of contact lenses, dioptric glasses/sunglasses;

o) contraceptive care, medicine costs;

p) care for the termination of pregnancy (except in cases of termination of pregnancy to preserve the health of the mother, to save her life, or in cases of termination of pregnancy that occurred in connection with a criminal offence);

q) care related to the investigation and treatment of infertility;

r) care related to artificial insemination;

s) occupational health and other aptitude tests;

t) transplantation;

u) sterilisation surgery and its consequences;

v) surgery to changing sex characteristics;

w) eye correction surgery;

x) hearing aid;

y) tests or treatment related to alcohol or drug use;

z) the cost of purchasing and administering vaccines (except for the flu vaccine - if this is covered by the contract);

aa) care in a nursing home;

bb) medical or other health care provided by a person who is not medically qualified and licensed, or subsequently required as a result of treatment by such a person;

cc) treatment necessary to avoid a life-threatening emergency (except for emergency care, emergency dentistry cover(s) - if such cover(s) are included in the contract);

dd) expert activities in the context of health care;

ee) care due to disaster;

ff) care provided in epidemiological interest;

gg) addiction treatment;

hh) specialist occupational health care;

ii) dental diagnostics, specialist care;

jj) laser nail fungus removal;

kk) geriatric treatment and care;

ll) digital dermatoscopy;

mm) treatment of varicose vein disease by injection (sclerotherapy);

nn) intensive care;

oo) clinical oncology care;

pp) Care for people living with HIV;

qq) Care of hepatitis C patients;

rr) anaesthesia care (excluding care related to same-day surgery and endoscopy procedures and anaesthesia related to in-patient hospital care);

ss) in respect of same-day surgery, for examinations and treatments for which the prescribing doctor's recommendation/referral is not issued by a specialist doctor (the recommendation/referral issued by a general practitioner will not be accepted by the Insurer even if the general practitioner may also perform specialist duties);

tt) interventions as follows: sterilisatio laparoscopica feminae, sterilisatio laparoscopica with staple, sterilisatio laparoscopica with ring, sterilisatio laparoscopica with monopol. electrodes, sterilisatio laparoscopica with bipol. electrodes, laparoscopic surgery of extrauterine graviditas, laparoscopic embryo aspiration from salpingotomy, intra-abdominal drug abortion, extra-abdominal drug abortion, injection to ectopic pregnancy, laparoscopic interruptio with vacuum, interruptio with Hegar dilation, curettage, interruptio with laminaria dilation, termination of interruptio with medication, infertility procedures, artificial insemination, plastic surgery for cosmetic reasons, procedures for nasal septum deviation, any form of varicose vein surgery;

uu) for in-patient care, the costs of priority level (V.I.P.) health care (e.g. single room);

vv) compulsory vaccinations and screenings (resulting from legislation) in the context of compulsory maternal and child protection;

ww) for the following diagnostic tests: faecal genomics test, IgG food intolerance test (FOOD test), histamine intolerance test, FABER multiplex allergy test, hair diagnostics, capsule endoscopy, CT laser mammography, stereotaxic biopsy;

xx) for insurance events related to the following sports activities: scuba diving below 40m with respirator, one-handed or open sea sailing, white water rafting, hydrospeed, canyoning, surf, mountaineering, rock climbing from V grade, high mountain expeditions, caving, cave expeditions, bungee jumping, private/sports aviation/aviation (e.g. base jumping, aerobatics, skydiving, paragliding, hang gliding, ballooning, powered gliding, ultralight flying, hot air ballooning, gliding, motorised sports (e.g. auto-crash, go-karting, moto-cross, speedboat sports, motorcycle sports, rally, skilled car racing), quad.

18) Declarations, obligation to notify changes

a) The Policyholder and the Insured Party must notify the Insurer in writing within 5 days of any change in their personal data (e.g. address) and of any change in circumstances relevant to the Insurer's assumption of risk. A material circumstance is something that the Insurer asked about in writing in the offer, in the health declaration and during the medical examination when the contract is concluded.
b) Declarations of rights, the validity of which is required by law to be in writing, shall be effective against the Insurer only if they are submitted in writing to the Insurer (1097 Budapest, Könyves Kálmán krt. 11. Building B). In case the law does not require the written form for the validity of a given declaration, the receipt of an electronic mail containing a scanned version of a paper document signed by the person entitled to do so shall replace the written submission.
c) All legal declarations are effective when received by the Insurer (1097 Budapest, Könyves Kálmán krt. 11. building B).
d) In the event of breach of the obligation to notify the change, the Insurer's obligation shall not arise unless the Policyholder or the Insured Party proves that the concealed or unreported circumstance was known to the Insurer at the time of conclusion of the contract or did not contribute to the occurrence of the insured event.
e) Notwithstanding the breach of the obligation to notify changes, the Insurer's obligation arises if 5 years have already elapsed from the day after the expiry of the deadline for notification of changes until the occurrence of the insured event.
f) If the contract applies to several persons and the breach of the obligation to notify changes only arises in relation to some of them, the Insurer may not invoke the breach of the obligation to notify changes in relation to the other persons.
g) The obligation to notify changes is the responsibility of both the Policyholder and the Insured Party. Neither of them may rely on any circumstance which any of them failed to notify the Insurer of when they should have known about it and were obliged to do so.

19) Termination of risk bearing

In relation to each Insured Party, the Insurer shall cease to bear the risk

a) if the contract is terminated - within 24 hours of the date of termination;
b) if the Insured Party ceases to belong to a group covered by the Contract (including, but not limited to, due to: termination of student status, leave, reorganisation, suspension, retirement) - in the month in which the membership of the group ceases, on the 24th hour of the last day of the month;
c) when reaching the maximum insured age - on the last day (24th hour of the day) of the calendar year in which the Insured Party reaches the age of 70;
d) in the case of the death of the Insured - on the date of death.

20) Termination of the insurance contract

The insurance contract is terminated:

a) in the absence of an extension, in the 24th hour of the last day of the fixed term;
b) upon the termination of the Policyholder without legal succession - in the 24th hour after the date of termination;
c) due to non-payment of fees as set out in Section 13)h);

d) if the number of Insured Parties is reduced to zero, at 24:00 on the last day of the month in which the last Insured Party leaves the scheme;
e) by ordinary termination, if the Policyholder or the Insurer terminates the contract of indefinite duration in writing no later than 30 days before the insurance renewal date - at the end of the insurance period;
f) by mutual agreement between the Policyholder and the Insurer - on the day indicated in the mutual agreement, at 24:00.

21) Principles and Practices Concerning the Processing of the Personal Data of Clients

Privacy Notice

a) Legal ground for the processing of the insurer, scope of the processed data

Insurance and reinsurance companies shall be entitled to process personal data during the life of the insurance or reinsurance contract or other contractual relation, and as long as any claim can be asserted in connection with the insurance, reinsurance or contractual relation. The processing of such data shall take place only to the extent necessary for the conclusion, amendment and maintenance of the insurance contract and for the evaluation of claims arising from the contract or for any other purpose specified in Act LXXXVIII of 2014 (hereinafter: 'Insurance Act'). Processing for any other purpose may be performed by the insurer or reinsurer only with the prior consent of the client. The client shall not suffer any disadvantage if the consent is not granted, nor shall they be granted any advantage if consent is provided.

aa) Your personal data are processed by the insurer for the performance of the insurance contract. The scope of the processed data includes the personal data provided when making an offer and any additions thereto, or for the performance of the contract. {Pursuant to Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 (GDPR) "on the Protection of Natural Persons with Regard to the Processing of Personal Data and on the Free Movement of Such Data, and Repealing Directive 95/46/EC (General Data Protection Regulation)": Article 6 (1) b) of the GDPR (processing necessary for the performance of a contract)}

ab) Part of the personal data are processed by the insurer in order to fulfil a legal obligation. Such data are necessary for the issuance of a tax certificate, for the fulfilment of an obligation under anti-money laundering measures. These data are related to the performance of the insurance contract, its financial records and the fulfilment of the obligation to make copies of documents. The scope of these personal data does not go beyond the data processed by the insurer in the performance of the contract. (Article 6 c) of the GDPR)

ac) Some personal data may be processed on the basis of the legitimate interests of the insurer or a third party. Such personal data may be processed in the course of claims against the injuring party and other similar claims handling. The scope of the data processed in this case is the same as the scope of the data listed in the processing necessary for the performance of the insurance contract (Article 6(f) GDPR)

ad) In the context of the performance of certain contracts or legal obligations, the insurer processes data in a special category of personal data with your consent. Such personal data include health data, the knowledge of which is indispensable for the settlement of health-related life, accident, sickness and liability insurance and personal injury claims.

In the case indicated in paragraph ad), you may object to the processing of your personal data in the special category of personal data, but this may result in non-performance by the insurer.

b) Data of the Controller and its supervisory authorities

Controller: CIG Pannónia Életbiztosító Nyrt. / CIG Pannónia Első Magyar Általános Biztosító Zrt. 1097 Budapest Könyves Kálmán krt. 11. Building B).

The name and contact details of the Data Controller's representative and the Data Protection Officer are posted on the website of the Insurer and in the Customer Service. This information can also be obtained from the insurance broker office of the dependent insurance intermediary agent.

Main establishment: 1097 Budapest Könyves Kálmán krt. 11. Building B, even if the insurer processes personal data within the scope of its cross-border activities.

Supervisory authority: National Bank of Hungary (address: 1013 Budapest, Krisztina krt. 39
phone: +36 80 203 776, fax: +36 1 489 9102; E-mail: ugyfelszolgalat@mnb.hu;
postal address: 1534 Budapest, BKKP P. O. Box: 777
https://www.mnb.hu/fogyasztovedelem/biztositasok)

Supervisory Authority (for data protection): National Authority for Data Protection and Freedom of Information (address: 1055 Budapest, Falk Miksa utca 9-11, postal address: 1374 Budapest, P.O. Box: 603; contact details: Phone: +36 1 391 1400, fax: +36 (1) 391-1410; E-mail: ugyfelszolgalat@naih.hu; URL http://naih.hu)

c) Specific processing operations and Processors

The Processors are authorised to perform technical operations on personal data on behalf of the insurer, in accordance with the instructions and purposes given by the insurer, without taking any decisions on the personal data. The identity of each Processor, the scope of the data transferred to them and the list of technical operations performed are published by the insurer on its website and are available to everyone. The identity of the Processors may change during the term of the contract.

d) Role of insurance intermediaries

The processing of the tied insurance intermediary is subject to the provisions applicable to the insurer, with the limitation that they are entitled to process the personal data that are necessary to establish and maintain the contract and to establish their eligibility for remuneration. The independent insurance intermediary is an independent controller who transfers the personal data of the client to the insurer in order to establish the insurance contract. When a contract is concluded, the personal data received from the independent insurance intermediary are processed by the insurer as an independent controller.

e) Rights of data subjects in relation to the processing of their personal data

Right to information

You may request information on the processing of your personal data, verbally or in writing, before the contractual relationship is established, or, failing that, when you provide your personal data. The request for information shall be considered by the insurer within the shortest possible time from the date of recording of the personal data or, in other cases, from the date of its submission, but not later than 25 days, and the decision shall be notified to the data subject in writing or, if the data subject has submitted the request by Electronic Means, by Electronic Means. Verbal information is subject to the prior verification of identity and the prior determination of the entitlement to information.

Access right
The insurer publishes its general information on the processing of personal data on its website. The insurer shall provide information on the processing of individual personal data and on the data processed on the basis of a written or verbal request from the data subject.
Right to rectification
You may request the rectification of your data or the supplementation of incomplete data. In order to comply with their request, the insurer may request a document from the data subject, on the basis of which it performs the rectification or supplementation without delay, but no later than within 3 working days.
The insurer sends written notification of the rectification of the personal data to the data subject.

Right to erasure (to be forgotten)
The insurer erases the personal data of the data subject without undue delay, but at the latest within 3 working days, on the grounds set out in the Data Protection Regulation. Such grounds shall exist if

- the personal data requested to be erased are no longer needed for the purpose they were obtained for and otherwise processed;
- the data subject revokes their consent forming the basis for processing, and there is no other legal ground for the processing;
- the data subject objects to the processing and there is no overriding legitimate ground for the processing, or the data subject's personal data were processed for direct marketing purposes and for related profiling,
- the personal data of the data subject are being or were unlawfully processed by the insurer;
- the personal data have to be erased for compliance with a legal obligation in Union or Member State law to which the controller is subject;
- the personal data were obtained in connection to the provision of services relating to the information society.

If the processing is based solely on the data subject's consent, the insurer shall, at the data subject’s request, erase the data subject's personal data without undue delay, but at the latest within 3 working days.

If the policyholder withdraws their consent which is the legal ground for the processing of their health data and there is no other legal ground for the processing, the insurer shall erase the policyholder's health data without undue delay, but at the latest within 3 working days, as specified in the Data Protection Regulation. As a consequence of the withdrawal, if the processing of the policyholder's health data is indispensable for the assessment of a claim for any of its services, the contract shall terminate on the last day of the month following the withdrawal, with payment of the current surrender value.

In certain cases, where the processing of the personal data of the data subject is strictly necessary for the performance of the tasks of the insurer as defined by law and the data subject has given their explicit consent to the processing of the personal data, the insurer may, in the event of withdrawal of that consent, continue to process the personal data if its legitimate interest is justified by a interest balancing test.

The insurer shall notify the data subject in writing of the erasure of the personal data.

Right to restriction of processing

You may request the restriction of processing if

- you contest the accuracy of the personal data, in which case the restriction shall apply for the period which
- allows the Controller to verify the accuracy of the personal data;
- the processing is unlawful, but you oppose the erasure of the data and instead request the restriction of their use;
- the insurer no longer needs the personal data for data processing purposes, but the data subject requests the data for the submission, enforcement or defence of legal claims; or
- the data subject has objected to processing by the insurer on the basis of legitimate interests; in such cases the restriction shall only apply to the period necessary to determine whether the Controller's justified needs precede the needs of the data subject.

Where processing has been restricted, such personal data shall, with the exception of preservation, only be processed with the consent of the data subject or for the submission, enforcement or defence of legal claims or for the protection of the rights of another natural or legal person or for reasons of important public interest of the European Union or of a Member State.

Right to data portability

The data subject is entitled to receive the personal data concerning them and made available to the insurer, in a structured, widely used, machine-readable format, and is entitled to request the insurer to transfer such data to another data controller. The transfer is subject to the condition that the personal data of the data subject are processed by the insurer based on their consent or that the processing is based on a contract and is performed by automated means.

The right to data portability must not adversely affect the rights and freedoms of others.

Right to objection

The data subject has the right to object at any time, on grounds relating to their particular situation, to the processing of their personal data by the insurer, its processor or a third party for reasons necessary for the purposes of the pursuit of their legitimate interests, including profiling. In such a case the insurer shall no longer process the personal data unless it demonstrates compelling legitimate grounds for the processing, which override the interests, rights and freedoms of the data subject, or for the submission, enforcement or defence of legal claims.

Where personal data are processed for direct marketing purposes, the data subject shall have the right to object at any time to the processing of personal data concerning them for such purposes, which includes profiling to the extent that it is related to such direct marketing. Where the data subject objects to processing for direct marketing purposes, the personal data shall no longer be processed for such purposes.

Contact details of the National Authority for Data Protection and Freedom of Information:
Registered office: 1055 Budapest, Falk Miksa u. 9-11
Mailing address: 1363 Budapest, Pobox.: 9
Phone: +36 1 391 1400
Telefax: +36 1 391 1410
E-mail: ugyfelszolgalat@naih.hu
Web: naih.hu

Right of judicial remedy

The data subject may take legal action against the Controller or, in the context of processing operations within the scope of the controller's activities, against the Processor, if they consider that the Controller or the Processor, acting on its behalf or under its instructions, is processing their personal data in breach of the provisions on the processing of personal data laid down by law or by a legally binding act of the European Union.
If so requested by the data subject, the case may be brought before the general court in whose jurisdiction the data subject's home address or temporary residence is located.

Provisions relating to insurance secrets

Insurance secret means all data, other than classified information, in the possession of the insurer, reinsurer and insurance intermediary that pertain to the personal circumstances and financial situations (or business affairs) of their clients (including claimants), as well as the contracts of clients with the insurer and reinsurer. Unless otherwise provided for by law, the owners, directors and employees of insurers and reinsurers, and all other persons having access to insurance secrets in any way or form during their activities in reinsurance-related matters shall be subject to the obligation of professional secrecy without any time limitation.

The health data related to the health status of the client, as defined in the Act on the Processing and Protection of Medical and other Related Personal Data (hereinafter: Eüak.), shall be stored by the Insurer in accordance with Section 135 (1) of the Act on Insurance Activities, for the purposes specified in the Act only with the express consent of the data subject.

The insurer and reinsurer shall be allowed to process the data of clients which are considered insurance secrets only to the extent that they relate to the relevant insurance contract, with its creation and registration, and to the service. The processing of such data shall take place only to the extent necessary for the conclusion, amendment and maintenance of the insurance contract and for the evaluation of claims arising from the contract or for any other purpose specified in Act LXXXVIII of 2014 (hereinafter:

'Insurance Act').Processing for purposes other than the above may be performed by the insurer and the reinsurer only with the prior consent of the client. The client shall not suffer any disadvantage if the consent is not granted, nor shall they be granted any advantage if consent is provided.

The insurer or reinsurer may disclose to a third party data which it has received in the course of its own activities or those of its agent and which are classified as insurance secrets, except in the cases provided for in the Insurance Act, if

- the client of the insurer or reinsurer or their representative has given their prior written consent, specifying precisely the insurance secrets which may be disclosed,
- there is no obligation of confidentiality under the Insurance Act,
- and if the certification body, including its subcontractor, hired by an insurer or reinsurer, received such confidential information during the certification process.

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

a) the Supervisory Authority acting in its official capacity,

b) the body conducting preparatory proceedings, the investigating authority and the public prosecutor's office,

c) the court of law in connection with criminal cases, civil actions and non-contentious proceedings, and the court proceeding in administrative cases, including the experts appointed by the court, and the independent court bailiff, the administrator acting in bankruptcy proceedings, the temporary administrator, extraordinary administrator, liquidator acting in liquidation proceedings in connection with a case of judicial enforcement, the principal creditor in debt consolidation procedures of natural persons, the Családi Csődvédelmi Szolgálat (Family Bankruptcy Protection Service), the family administrator, the court,

d) notaries public, including the experts they have appointed, in connection with probate cases,

e) financial institutions provided for in the Credit Institutions Act in connection with insurance contracts linked to claims arising out of financial services, if the financial institution makes a written request to the insurer indicating the name of the client or the description of the insurance contract, the type of data requested and the purpose for its requesting,

f) the national security service acting in its official capacity,

g) the Hungarian Competition Authority acting in its official capacity,

h) the guardianship authority acting in its official capacity,

i) the healthcare authority defined Section 108 (2) of Act CLIV of 1997 on Health Care,

j) the body authorised to collect confidential information, under the conditions laid down by law,

k) providers of reinsurance, other members of the group and, in the case of co-insurance, with the underwriters,

l) the bureau of insurance policy records maintaining the central policy records with respect to data transmitted as governed by law, the claims records agency keeping accident and claims records, the traffic control authority in connection with road transport administrative actions relating to vehicles which are not listed in the motor vehicle registry, and the body operating the register of motor vehicles,

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

n) with respect to the information required for settlement and for the enforcement of compensation claims, and also for the conveyance of these among one another, the body

operating the Compensation Fund and the Claims Guarantee Fund, the National Bureau, the correspondent, the Information Centre, the Claims Organisation, claims representatives and claims adjustment representatives, or the responsible party if wishing to access - in exercising the right of self-determination - the particulars of the other vehicle that was involved in the accident from the accident report for the purpose of settlement,

o) the party performing the outsourced activity with regard to the data required for such activity, and the auditor in respect of the data necessary for the performance of the auditing tasks,

p) in the case of a branch, if the conditions for data processing meeting the requirements of Hungarian law are fulfilled for each item of data and the State in which the third-country insurer is established has data protection legislation meeting the requirements of Hungarian law, the third-country insurer or insurance intermediary,

q) the commissioner of fundamental rights acting in its official capacity,

r) the National Authority for Data Protection and Freedom of Information acting in its official capacity,

s) the insurer in respect of the bonus-malus system and the bonus-malus rating, and the claims record and the bonus-malus rating in the cases specified in the regulation on the detailed rules for the verification of casualties,

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

u) the authority maintaining a register of liquidator companies,

v) MABISZ with regard to the data provided in the e-reporting interface under the MTPL Act for the operation of the reporting application, the collection of the necessary information relating to the insured event and the transfer of such information to insurers for the purpose of settling claims,

if the body or person referred to in paragraphs a) to j), n), s), t) and u) of Section 138 of the Insurance Act submits a request for data or a written request to it, which includes the name of the client or the insurance contract, the type of data requested, the purpose and the legal ground of the request, on the understanding that the body or person referred to in Section 138 p) to s) of the Insurance Act is obliged to indicate only the type of data requested, the purpose and the legal ground of the request. An indication of the statutory provision granting authorisation for requesting data shall be treated as verification of the purpose and legal grounds.

The insurer and reinsurer shall be required to supply information without delay when requested to so by the national security service, the body conducting preparatory procedure, the investigative authority, the public prosecutor's office or the court, and if there is any suspicion that an insurance transaction is associated with:

a) the misuse of narcotic drugs, illegal possession of new psychoactive substances, acts of terrorism, criminal misuse of explosives or blasting agents, criminal misuse of firearms and ammunition, money laundering, or any felony offence committed in criminal conspiracy or within the framework of a criminal organisation pursuant to Act IV of 1978 in force until 30 June 2013,

b) unlawful drug trafficking, possession of narcotic drugs, inciting substance abuse, aiding in the manufacture or production of narcotic drugs, illegal possession of new psychoactive substances, acts of terrorism, failure to report a terrorist act, terrorist financing, criminal misuse of explosives or blasting agents, criminal misuse of firearms and ammunition, money laundering, or any felony offence committed in criminal conspiracy or within the framework of a criminal organisation pursuant to the Criminal Code.

The obligation to maintain insurance secrecy does not apply if the Insurer or reinsurer complies with the obligation to notify as specified in the law on the implementation of financial and property restrictive measures imposed by the European Union and the UN Security Council.

Data transfer pursuant to Section 164/B of the Credit Institutions Act does not constitute violation of insurance secrets.

In the supervisory review process, the disclosure of the group investigation report to the managing member of the financial group in the case of group supervision does not constitute a breach of the obligation of insurance and business confidentiality.

The obligation to keep insurance secrets shall not apply when:

a) a Hungarian law enforcement agency requests in writing from the insurer information that is an insurance secret for the purpose of fulfilling a written request from a foreign law enforcement agency under an international commitment.
b) an authority acting as a financial intelligence unit, acting within the scope of its duties as defined in Act LIII of 2017 on the Prevention and Combating of Money Laundering and Terrorist Financing or in order to comply with a written request from a foreign financial intelligence unit, requests in writing information classified as an insurance secret, and if the insurer or reinsurer is fulfilling its obligations in relation to the anti-money laundering and anti-terrorist financing policy and procedure defined at group level.

It shall not constitute a violation of an insurance secret where an insurer or reinsurer supplies information to a third-country insurer or reinsurer or a third-country data processing agency:

- if the client of the insurer (hereinafter: 'data subject') has given their written consent
- if, without the consent of the data subject, the transfer complies with the requirements for the transfer of personal data to a third country.

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

The following shall not be deemed a violation of insurance secrets:

a) disclosure of summarised information from which the clients and/or the specifics of their business cannot be identified;
b) in respect of branch offices, transfer of data to the supervisory authority of the country where the registered address (main office) of the foreign-registered enterprise is located, if such transfer is in compliance with the agreement between the Hungarian and the foreign supervisory authorities;

c) disclosure of information, other than personal data, to the minister for legislative purposes and in connection with the completion of impact assessments,
d) the disclosure of data in order to comply with the provisions contained in the Act on the Supplementary Supervision of Financial Conglomerates.

Insurer and reinsurer may not refuse to disclose the data specified in paragraphs a) to d) on the grounds of protection of insurance secrets.

In the provision of certain insurance services, the insurer uses external intermediaries in cases where the special expertise of the intermediary is required for the provision of the service. The outsourcing agent handles personal data and is bound by law to maintain confidentiality.

It does not constitute a breach of the Insurer's duty of confidentiality or trade secrecy if the disclosure of information by the insurer to the tax authorities is only to comply with the obligation specified in Sections 43/B-43/C of Act XXXVII of 2013 on certain rules for international administrative cooperation in relation to taxes and other public charges (Aktv.), based on the provisions of Act XIX of 2014 on the Announcing of the Agreement between the Government of Hungary and the Government of the United States of America to Improve International Tax Compliance and to implement FATCA, and the amendments of certain related laws (hereinafter: “FACTA Act”).
It does not constitute a breach of an insurance secret if the provision of information by the insurer to the tax authority consists in the fulfilment of the obligation under Section 43/H of the Aktv. and the obligation under Sections 43/B and 43/C of the Aktv., based on the FATCA Act.

The insurer (for the purposes of Section 149 of the Act on Insurance Activities: requesting insurer) may, in order to protect the interests of the risk pool and to provide the services in accordance with the law and the contract, in the course of the performance of its statutory or contractual obligations, request another insurer (for the purposes of Section 149 of the Act on Insurance Activities: requested insurer) to provide information in relation to data controlled by the latter insurer and as stipulated in Sections 149 (3)-(6) of the Act on Insurance Activities, in consideration of the stipulations in Section 135 (I) of the Act on Insurance Activities and the peculiarities of the insurance product, to prevent abuse of insurance contracts, provided that the requesting insurer's right to do so has been recorded in the insurance contract. When making such a request, the insurer shall comply with the provisions of Sections 149 - 151 of the Act on Insurance Activities.

“Section 149 (2) The requested insurance company shall make available to the requesting insurance company the data requested in due compliance with the law, inside the time limit specified in the request, or failing this, within fifteen days from the date of receipt of the request.
(3) The requesting insurance company may request the following data in connection with the performance of contracts under the branches referred to in Points 1 and 2 of Part A) of Annex 1, and also in Annex 2:
  a) the identification data of the policyholder, the insured person and the beneficiary;
  b) information relating to the state of health at the time of recording of the insured person in connection with the risk covered;

c) information concerning the insurance history of the persons referred to in paragraph a), listing previous settlements under the branch to which this Subsection pertains;
d) information relating to the assessment of risk in connection with any policy provided by the requested insurance company; and
e) information for verifying the legal grounds for a settlement to be paid in connection with any policy provided by the requested insurance company.

(4) The requesting insurance company may request the following data in connection with the performance of contracts under the branches referred to in Points 3-9 and 14-18 of Part A) of Annex 1:
a) the identification data of the policyholder, the insured person, the beneficiary and the injured party;
b) any data necessary for the identification of the insured assets, claims or property rights;
c) any data related to the Insured Events that occurred in relation to the assets, claims or property rights specified in subsection b);
d) information relating to the assessment of risk in connection with any policy provided by the requested insurance company; and
e) information for verifying the legal grounds for a settlement to be paid in connection with any policy provided by the requested insurance company.

(5) The requesting insurance company may request the following data in connection with the performance of contracts under the branches referred to in Points 10-13 of Part A) of Annex 1:
a) subject to the injured party's prior consent, the identification data of the injured party;
b) the identification data of the policyholder, the insured person, the beneficiary, and the data referred to in Paragraphs b)-e) of Subsection (4);
c) subject to the injured party's prior consent, information relating to the state of health at the time of recording of any person seeking settlement for personal injury or restitution for any violation of personality rights, in connection with the risk covered;
d) information, with all personal data removed, concerning the insurance history related to the damaged property or asset, listing previous settlements under the branch to which this Subsection pertains;
e) subject to the injured party's prior consent, information concerning the insurance history of the persons seeking settlement for personal injury or restitution for any violation of rights relating to personality, listing previous settlements under the branch to which this Subsection pertains.

(6) The requesting insurance company may request the information in connection with the performance of contracts under the branches referred to in Points 3 and 10 of Part A) of Annex 1, based on the vehicle's identification data (registration plate number, chassis number), with or without the injured party's prior consent relating to losses under the branch referred to in Point 10 of Part A) of Annex 1:
a) information concerning the insurance history related to the vehicle in question, such as in particular the dates when the losses occurred, the legal basis, how the vehicle was damaged and information as to the settlement for covering such losses, including the damages sustained by the motor vehicle indicated by the requesting insurance company, caused by means other than a motor vehicle,

b) the findings of the assessment of damages performed by the insurance company on the vehicle in question, and the amount of damages.

(7) The request made according to Subsection (1) shall contain the information necessary for the identification of the person, property or right defined therein, it shall specify the type of data requested and the purpose of the request. A request and the response to such request shall not be construed as a violation of insurance secrets. The responsibility for ascertaining that the request is legitimate as provided for under Subsection (1) lies with the requesting insurance company.

(8) The requesting insurance company shall be allowed to process data obtained through the request for a period of ninety days from the date of receipt.

(9) If the data obtained by the requesting insurance company through the request is necessary for the enforcement of that insurance company's lawful interest, the time limit specified in Subsection (8) for data processing shall be extended until the conclusion of the procedure opened for the enforcement of such claim.

(10) If the data obtained by the requesting insurance company through the request for the enforcement of that insurance company's lawful interest, and the procedure for the enforcement of such claim is not opened inside a period of one year after the data is received, such data may be processed for a period of one year from the date of receipt.

(11) The requesting insurance company shall inform the client affected by the request concerning the request made according to Subsection (1) and also if the request is satisfied, on the data to which it pertains, at least once during the period of insurance cover.

(12) If the client requests access to their personal data and the requesting insurance company no longer has - having regard to paragraphs (8)-(10) - the data to which the request pertains, the client shall be informed thereof.

(13) The requesting insurance company shall not be allowed to connect the data obtained through the request relating to an interest insured, with data it has obtained or processed, for purposes other than those provided for in subsection (1).

(14) The requested insurance company shall be responsible for the correctness and relevance of the data indicated in the request.

150. § (1) Insurers shall, in relation to the contracts belonging to the segments specified in Sections 3-6 of Part A of Annex 1 to the Act on Insurance Activities, in order to protect the interests of the risk pool, set up a common database (hereinafter referred to as "Database") for the purpose of performing services in accordance with the law and the contract, and of detecting abuses in relation to insurance contracts, which contains

a) the identification data of the policyholder;

b) the particulars of the insured property;

c) information concerning the insurance history related to the policyholder or the property referred to in Paragraphs a) and b), respectively, listing previous settlements; and

d) the name of the insurance company and the policy number.

(2) The insurance company shall send the data defined in Subsection (1) to the Database within 30 days from the date of origin of the data in question.

(3) In order to protect the interest of risk groups, in discharging the obligations delegated by law or fulfilling their contractual commitments and in order to provide services in compliance with the relevant legislation or as contracted, and

to prevent insurance fraud, insurance companies may request data from the Database.

(4) If the request is made in compliance with the relevant legislation, the operator of the Database shall make available to the requesting insurance company the data requested within 8 days.

(5) The obligation of professional secrecy shall not apply to insurance companies toward the Database, with respect to data disclosed to the Database; moreover, the obligation to keep insurance secrets shall not apply to the operator of the Database with respect to insurance companies, if the request is submitted in accordance with the relevant legislation.

(6) The provisions relating to insurance secrets shall apply mutatis mutandis to the obligation of professional secrecy of the operator of the Database relating to data contained in the Database, and to compliance with requests for data.

(7) If it is not possible to respond to the request without the possession of the requested data, the Database Manager shall forward any request for information submitted to it in accordance with Section 138 (3) and Subsections (b), (f), (q), (r) of Section 138 (1), to the insurers authorised to operate in the insurance segment concerned by the request. The operator of the Database shall notify the requesting party when forwarding his request.

(8) The requesting insurance company shall not be allowed to connect the data obtained through the request relating to an interest insured or to be insured, with data it has obtained or processed, for purposes other than those provided for in Subsection (3).

(9) The sending insurance company shall be responsible for the correctness and relevance of the data forwarded in the Database.

(10) The data specified in Subsection (1) may be processed for a period of five years following the date of registration, with the exception set out in Subsection (11).

(11) If the insurance contract is concluded, the data referred to in Subsection (1) may be processed during the life of the contract, until the term of limitation of the claims arising out of, or in connection with, the contract, in the registry specified in Subsection (1). The insurance company shall notify the operator of the Database when the contract is terminated and when the claims arising out of, or in connection with, the contract are no longer enforceable.

(12) The insurance company requesting data from the Database shall be allowed to process the data so obtained for a period of ninety days from the date of receipt.

(13) If the data obtained by the requesting insurance company through the request is necessary for the enforcement of that insurance company's lawful interest, the time limit specified in Subsection (12) for data processing shall be extended until the final conclusion of the procedure opened for the enforcement of such claim.

(14) If the data obtained by the requesting insurance company through the request for the enforcement of that insurance company's lawful interest, and the procedure for the enforcement of such claim is not opened inside a period of one year after the data is received, such data may be processed for a period of one year from the date of receipt.

(15) The insurance company requesting data from the Database shall be allowed to process the data so obtained only for the purpose defined in Subsection (1).

(16) The requesting insurance company shall inform the client concerning the request made according to paragraph (3), on the data to which it pertains, and

also on compliance with the request at least once during the period of insurance cover, and shall provide access to the personal data at the request of the client.

Section 151 (1) Insurance companies shall be able to set up the Database defined in Section 150 (1) if two-thirds of the insurance companies engaged in the pursuit of the classes of insurance referred to in Section 150 (1) - calculated according to their market share existing prior to the conclusion of the agreement - agreed to establish the database, on the conditions of participation and sharing the costs of operating the Database.

(2) Furthermore, another prerequisite for setting up the Database is that the insurance companies providing data for the Database install a clause in the contracts affected as regards the possibility of disclosure and transmission of, and allowing access to, data made available for the Database.

22) Other provisions

a) The policyholder is obliged to inform the insured party of the content of the insurance, the content of the notifications addressed to them concerning the insured party and any changes to the contract.

b) **The limitation period for claims arising from the insurance is 5 years.**

c) In the event of a complaint concerning the conduct, activity or omission of the Insurer or in connection with these terms and conditions, the client may submit the complaint orally (in person, by telephone) or in writing (in person or by a document delivered by another person, by post, by fax, by e-mail) in the first instance to the Customer Service Office of CIG Pannónia Életbiztosító Nyrt. (1097 Budapest, Könyves Kálmán krt. 11. Building B., Phone: +36-1-5-100-200, e-mail: ugyfelszolgalat@cig.eu).

If the Policyholder submits a complaint to the Insurer and it is necessary to include the Insured Party's health details in the response to the complaint, the Insurer will respond to the complaint directly to the Insured Party, provided that the Insured Party's contact details are included in the complaint. In the event of such complaints, the Policyholder shall indicate the contact details of the Insured Party concerned in the complaint.

The professional supervision of the insurer is exercised by Magyar Nemzeti Bank (1013 Budapest, Krisztina krt. 39, 1014 Budapest and 1534 Budapest BKKP P.O. Box 777).

If the complaint is rejected or if the statutory deadline of 30 days to respond to the complaint has expired without result, the client may turn to the following bodies or authorities:

- Financial Consumer Protection Centre of Magyar Nemzeti Bank (registered office: 1013 Budapest, Krisztina krt. 39., 1013 Budapest, website: http://www.mnb.hu/fogyasztovedelem, postal address: 1534 Budapest BKKP Pobox: 777., Phone: 06-80-203-776, e-mail: ugyfelszolgalat@mnb.hu);
- Financial Arbitration Board (for disputes relating to the formation, validity, effects and termination of the contract, as well as for disputes relating to breach of contract and its effects, seat: 1054 Budapest, Szabadság tér 9., website: http://www.mnb.hu/bekeltetes, mailing address: H-1525 Budapest BKKP Pf.: 172., Phone: +36-80-203-776, e-mail: pbt@mnb.hu);
- the court indicated in the contracting terms and conditions.

For more information on complaints handling, please visit the Customer Service Office at the Insurance Company's head office and the Complaints Handling Policy published on www.cigpannonia.hu.

d) The Insurer shall refer complaints about the quality of the services provided by the Healthcare Service Providers, the quality of the service and possible medical errors to the organisation providing the care, given that it only pays the consideration for these services but does not actually provide the service.
e) The Healthcare Service Provider, and not the Insurer, is liable for damages resulting from the defective performance of medical and health care activities.
f) The applicable law in relation to the insurance contract concluded under these terms and conditions is the law of Hungary.
g) The provisions of Act V of 2013 on the Civil Code and other applicable Hungarian legislation shall prevail with respect to any matters not regulated in these Terms and Conditions.
h) All disputes arising out of the insurance as defined in these terms and conditions shall be decided by the courts of general jurisdiction, as governed by the provisions of Section 30 (1) of the Code of Civil Procedure.
i) A legal declaration relating to a contract is deemed to have been received when it is delivered, or attempted to be delivered, by registered post to the person concerned, or, in the case of a declaration delivered personally, when the person concerned acknowledges receipt in writing, or when the addressee has refused to accept it in the above cases.
j) The insurer must publish an annual report on its solvency and financial situation. The insurer shall publish the report on its solvency and financial situation on its website (www.cigpannonia.hu).
k) The insurer does not provide advice on the insurance product.

23) Key data of the insurer:

Name: CIG Pannónia Életbiztosító Nyrt.
Activity: the insurer carries out insurance activities
Address: MAGYARORSZÁG, 1097 Budapest, Könyves Kálmán krt. 11. Building B).
Postal address: 1476 Budapest, Pobox.: 325
Forint bank account number: 10300002-10315709-49020021
(IBAN) HU37 1030 0002 1031 5709 4902 0021
Euro bank account number: 10300002-10315709-48820055
(IBAN) HU02 1030 0002 1031 5709 4882 0055
Name (and SWIFT code) of the bank holding the account: MKB Bank Nyrt. (MKKBHUHB)
Legal form of the insurer: public limited company
Company Register No.: 01-10-045857
Our company is registered at the Company Registry Court of the Budapest-Capital Regional Court.