GENERAL TERMS AND CONDITIONS OF HEALTH INSURANCE CONTRACTS

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The general terms and conditions of health insurance contracts set out the definitions used in insurance contracts as well as the rights and obligations of the insurer, policyholder and insured person upon entering into and performing the contract.
The general terms and conditions apply to all health insurance services provided by the Estonian branch of ERGO Life Insurance SE insofar as the general terms and conditions are not in conflict with the special terms and conditions.

1 Definitions used in the general terms and conditions

1.1 Insurer is the Estonian branch of ERGO Life Insurance SE.
1.2 Policyholder is the person who has an insurable interest and who has entered into an insurance contract with the insurer.
1.3 Insurable interest is the interest of the policyholder in insuring their life or health or that of an insured person against a specific risk.
1.4 Insured person is the natural person specified in the insurance contract, for whose benefit the insurance contract has been entered into.
1.5 Beneficiary is the person agreed in the insurance contract, who has the right to receive insurance indemnity upon the occurrence of an insured event.
1.6 Insured risk is an event that is independent from the intention of the insured person, has been set out in the insurance contract and the occurrence of which in the future is likely.
1.7 Insured event is an event independent from the intention of the insured person, which is in causal relationship with the insured risk and upon the occurrence of which insurance indemnity is paid in accordance with the terms and conditions of the insurance contract.
1.8 Waiting period is the period of time starting from entry into the insurance contract, wherein no insurance indemnity will be paid for insured events occurring during that period. The duration of the waiting period is set out in the insurance contract. In the event of an accident, no waiting period is applied.
1.9 Accident is an unexpected and unforeseen event that occurs against the free will of the insured person and as result of which an external or violent force causes damage to the health of the insured person.
1.10 Deductible is the amount or percentage, agreed in the insurance contract, of the medical treatment expenses that must be covered by the policyholder or insured person in the case of an insured event.
1.11 Insurance application is a document in the form established by the insurer that the policyholder submits to the insurer. In the insurance application, the policyholder notifies the insurer of the material circumstances that the insurer needs to evaluate the likelihood of the insured risk.
1.12 Insurance offer is the proposal made by the insurer to enter into an insurance contract.
1.13 Insurance contract is an agreement entered into between the insurer and policyholder and consisting of the following parts:
- insurance application;
- policy;
- special terms and conditions (if agreed);
- terms and conditions of insurance;
- amendments and modifications to the insurance contract.

1.14 Terms and conditions of insurance are the terms and conditions that the insurer applies in a specific insurance relationship. Terms and conditions of insurance are deemed to include these general terms and conditions, the policy conditions of products of each insurance class and special terms and conditions.
1.15 Policy is a document issued by the insurer that confirms the entry into an insurance contract. The confirmation by the insurer's representative on the policy may be handwritten, digital or mechanically reproduced.
1.16 Payment notice is the message sent by the insurer that notifies the policyholder of the imminent payment deadline.
1.17 Insurance period is the period of time based on which insurance premiums are calculated. The duration of an insurance period is one year unless otherwise agreed in the insurance contract.
1.18 Insurance cover is the insurer's obligation, upon the occurrence of an insured event, to pay the sum insured or insurance indemnity or to perform the contract in any other manner.
1.19 Sum insured is the amount of money prescribed in the insurance contract to the extent of which the insurer pays the insurance indemnity upon the occurrence of an insured event.
1.20 Medical institution is a physician or a state or municipal institution that provides health services or a company entered in the register of the Health Board, which provides health services in compliance with legislation.
1.21 Application for indemnity is a document in a form established by the insurer, which the insured person submits to the insurer for receiving insurance indemnity. The application is available on the insurer's website at www.ergo.ee.
1.22 Health services are the services that have been provided to the insured person in a medical institution.
1.23 Written notification is sending information to the insurer, policyholder or another agreed person in a manner that allows for any later reproduction of the information. Information is sent to the postal address or e-mail address set out in the documents of the insurance contract. Information is deemed as delivered after it has been sent in the aforementioned manner.
1.24 Financial sanction is an international sanction that hinders the use and disposal of funds and economic resources of customers (i.e. subjects of the financial sanction) in full or in part.

2 Customer identification, representation and entry into an insurance contract

2.1 The insurer has the right to request that the customer or their representative present an identity document or a document certifying the right of representation in order to identify the person or certify the right of representation, and to make copies thereof.
2.2 If the insurer has any doubts about the identity of the person or accuracy of the submitted documents, the insurer has the right not to conclude the transaction or to request that additional documents be submitted.
2.3 Customer identification principles have been explained in more detail in the customer data processing principles (https://www.ergo.ee/erakliendile/isikuandmete-kaitse).
2.4 The insurer accepts an unattested authorisation document if it has been drawn up in the presence of the insurer's representative. In any other events the authorisation document certifying the right of representation must be digitally signed or notarially authenticated.
2.5 An insurance contract is entered into on the basis of an insurance application.
2.6 An insurance contract is deemed to have been entered into if the policyholder has met the following conditions:
- has confirmed the entry into the insurance contract with their signature;
- has paid the insurer the first insurance premium;
- has performed any other act agreed in the insurance contract.

2.7 The insurance contract is entered into without a term. The duration of an insurance period is one year unless otherwise agreed in the insurance contract. The insurer issues a new insurance policy for each insurance period unless otherwise agreed in the insurance contract.

2.8 An insurance contract may be entered into for a fixed term if it is related to training, staying in a foreign country, travelling or performing fixed-term work or operation.

2.9 If the insured person is not a policyholder, an insurance contract may only be entered into with the consent of the insured person. If the policyholder insures their child who is under their guardianship and has not attained 18 years of age by the time of entry into the insurance contract, the insurance application will be signed by the policyholder on behalf of the child.

2.10 The insurance cover is only valid for health services provided in Estonia. The insurer indemnifies expenses of health services provided outside of Estonia only if prescribed so in the insurance contract. The insurance cover is valid 24 hours a day.

2.11 The policyholder has the right to designate a third person as a beneficiary and change that person. In the event of medical treatment expenses, the beneficiary is a) the insured person themselves if they have paid the medical treatment expenses; or b) the medical institution that provided the agreed health services.

2.12 If the beneficiary dies or a legal person beneficiary terminates their activities before the occurrence of an insured event, the insurer must perform their obligation towards the successors of the insured person unless otherwise determined by the policyholder before the occurrence of an insured event.

2.13 The insurance premium is deemed as paid when the corresponding amount is credited to the insurer's bank account or is paid to the insurer's representative in cash or by payment card.

2.14 Delay in payment or failure to pay the first insurance premium.

2.14.1 If the policyholder has failed to pay the insurance premium or the first insurance premium within 14 days of entry into the insurance contract, the insurer may withdraw from the contract until the payment is made.

2.14.2 It is presumed that the insurer has withdrawn from the contract if the insurer does not file an action for the collection of the insurance premium within three months of the time when the premium becomes collectible.

2.14.3 If the first insurance premium has not been paid by the time when the insured event occurs, the insurer will be released from their obligation to perform the contract.

2.15 If the policyholder has failed to pay the second or a subsequent insurance premium by the due date, the insurer may send the policyholder a written notice in which the insurer determines for the policyholder a term of at least two weeks for the payment to be made and also announces the legal consequences of exceeding the payment term. If the policyholder pays the insurance premium within one month of the cancellation of the contract or expiry of the new payment term and no insured event has occurred before the payment, the contract will not be deemed cancelled.

2.16 The insurer submits to the policyholder, either on paper or electronically, a payment notice that sets out the due date of payment, the insurer's account number, and reference number.

2.17 If the insurer does not submit a payment notice or the policyholder does not receive the notice, this will not release the policyholder from their obligation to pay the insurance premium.

2.18 If the insurance premium has been paid incorrectly and the insurer is unable to decide, based on the information available, for which insurance contract the premium has been received, the insurance premium is deemed to be unpaid until it has been established for which insurance contract the premium has been paid.

2.19 If the policyholder pays an amount of money that is less than prescribed, the insurer will contact the policyholder. The insur¬ance premium is deemed paid only when the entire prescribed amount has been received.

2.20 If the policyholder pays an amount of money that is larger than prescribed, it will be refunded at the request of the policyholder.

3 Change of insurance premium and insurance cover

3.1 Following entry into the insurance contract, the insurer may increase the insurance premium or change the insurance cover, including, among other things, establish or change the deductible in the following events:

3.1.1 a change in a circumstance that is beyond the control of the parties and is specified in the insurance contract as the basis for calculating the insurance premium; for example, a change in the expenses that are connected with the operation of the insurer and are included in the overheads;

3.1.2 a change in the average age of the insured persons;

3.1.3 a change in the frequency of insured events;

3.1.4 a change in the degree of national compensation for health insurance service (if the degree of national compensation declines, the insurer's obligation increases and, as a result, it is substantiated to increase the insurance premium or change the insurance cover);

3.1.5 a change in the fees for health services (if the fees of the health care provider rise, the insurer's performance obligation also changes and, as a result, an increase in the insurance premium or change in the insurance cover is substantiated);

3.1.6 amendment of legislation organising health care administration (for example, if the insurer's performance obligation increases due to amendments to legislation).

3.2 The insurer has the right to increase the initial insurance premium, starting from a certain age of the insured person, up to an amount that the insurance premium rate prescribes for a person who enters into an insurance contract at that age. In each following insurance period, the insurance premium will increase by an amount equal to an increase in the insurance premium rate of the person who entered into the insurance contract.

3.3 The insurer notifies the policyholder of changes in the insurance contract at least one month in advance before entry into force of the changes.

4 Termination of the contract and refund of prepaid insurance premium

4.1 The policyholder may cancel a health insurance contract by giving at least one month's notice of the cancellation, taking into account that the contract expires upon expiry of the insurance period.

4.2 The insurer has the right to cancel a health insurance contract entered into for a shorter period than one year by giving at least three days' notice thereof.

4.3 The insurer has the right to ordinarily cancel a health insurance contract within the first three years by giving notice thereof one month in advance.

4.4 If the insurer increases the insurance premium or deductible or reduces their obligations, the policyholder may cancel the contract within one month of receiving the notice of change. In such an event, the insurance contract ends at the moment the increase in the insurance premium or the reduction in obligations enters into force.

4.5 The policyholder may withdraw from the insurance contract within 14 days of entry into the contract. To this end, the policyholder must submit a written withdrawal application to the insurer. If the policyholder withdraws from the contract, the insurer will refund the insurance premium paid by the policyholder, subtracting administration expenses according to the applicable price list.

4.6 Upon cancellation of and withdrawal from the contract, the policyholder has the right to refund of the insurance premium prepaid for the remaining insurance period, from which the insurer has the right to deduct 25% for administrative expenses. Upon refunding the insurance premium, account will be taken, among other things, of the degree to which the insurer already has or is about to have the obligation to pay indemnity.

5 Obligations of the policyholder and insured person. Insurer's notification obligation

5.1 Obligations of the policyholder and insured person.

5.1.1 The policyholder must pay insurance premiums.

5.1.2 Upon entry into a contract, the policyholder and insured person must notify the insurer of all material circumstances that are known to the policyholder or insured person and may have an impact on the insurer's decision to enter into the contract or do so under the agreed terms and conditions. A circumstance is material if the insurer has directly requested information about it in a format that can be reproduced in writing. If the policyholder or insured person has not notified the insurer, upon entry into the insurance contract, of all material circumstances known to the policyholder or insured person, or if the policyholder or insured

person has intentionally avoided a material cir¬cumstance becoming known to the insurer or has supplied incorrect information about a material circumstance, the insurer may, within three years of entry into the contract, either withdraw from the contract or demand a higher insurance premium from the policyholder.

5.1.3 The insured person is required to make all efforts for restoring their health and comply with the instructions of a medical specialist.

5.1.4 The policyholder or insured person is required to notify the insurer without delay of an increase in the insured risk; for example, if the occupation or area of activity of the insured person changes, the insured person starts to pursue a high-risk hobby or enters into the active service of the Defence Forces. If the new area of activity, profession, hobby, etc., of the insured person is subject to a higher insurance premium than before the change in the insured risk pursuant to the applicable rates, the insurer has the right to change the insurance premium by giving the policyholder at least one month's notice thereof.

5.2 Obligations of the policyholder and insured person upon occurrence of an insured event.

5.2.1 The policyholder and insured person are required to notify the insurer of each insured event in writing at the first available opportunity, apply all measures to identify the circumstances of the insured event and follow the insurer's instructions, if the circumstances allow for it.

5.2.2 The policyholder and insured person are required to help the insurer identify the circumstances of the insured event and to submit additional documents as requested by the insurer, which confirm the occurrence, place, date and time of the insured event (this applies to all certificates, invoices and payment documents).

5.2.3 The insured person is required to turn to a licensed physician or medical institution and follow the physician's instructions. If inpatient treatment is prescribed for the insured person, they must notify the insurer thereof without delay.

5.2.4 In the case of an insured event, the insured person is required to submit to a medical institution or physician the health insurance card issued by the insurer. If the insured person turns to a medical institution for emergency medical care and the institution has no cooperation agreement with the insurer, the insurer must be notified thereof at the first available opportunity.

5.2.5 At the request of the insurer, the insured person is required to pass a medical examination as determined by the insurer.

5.3 Insurer's notification obligation During the term of the insurance contract, the insurer is required to notify the policyholder of any amendments to the general and special terms and conditions of insurance and changes in the insurer's name, legal form or address as well as the address of the insurance supervision authority or the office where the insurance contract is entered into. The policyholder is notified of the aforementioned changes via the insurer's website www.ergo.ee or media.

6 Decision to pay or refuse to pay insurance indemnity, transfer of the right of claim

6.1 The insurer makes a decision to pay or refuse to pay the insurance indemnity within 10 working days of receiving all necessary documents.

6.2 The right of the insured person to request compensation for damage from the person who caused it transfers it to the insurer to the extent of the insurance indemnity paid (right of recourse).

6.3 If no right of recourse for the benefit of the insurer is created due to an act or omission of the insured person or policyholder, the insurer has the right to reduce the indemnity or request that the indemnity paid be refunded to the extent in respect of which no recourse can be filed.

6.4 The insurer has the right to withhold from the insurance indemnity the amount of the deductible prescribed in the insurance contract and the part of the insurance premium not paid for the insurance period, which corresponds to the percentage of the sum insured in which the insurer has performed the obligation.

6.5 After payment of the insurance indemnity, the sum insured will reduce by the amount of paid indemnity.

6.6 The insurer has the right to send information concerning the adopted decision to the insured person electronically by using the contact details (including e-mail address) of the insured person known to the insurer. If the insured person also wants to receive, in addition to the aforementioned information, the decision by post, they will notify the insurer thereof and give the address to which the decision should be sent. A notice of payment of insurance indemnity may also be sent via other communications channels specified in the application of the insured person.

6.7 The insurer is required, within 10 working days of receiving the application for indemnity, notify the insured person in writing as to which additional documents are necessary for making a decision on payment of insurance indemnity.

6.8 If the documents submitted for receiving insurance indemnity are incomplete, have been filled in incorrectly or additional time is needed for checking the insured event or documents submitted, the insurer has the right to postpone the adoption of the decision for up to one month.

6.9 The insured person must submit to the insurer, along with the application for indemnity, the invoice for the health services and, at the insurer's request, also a document certifying the payment of the invoice.

6.10 An extract from the medical history or medical record must be submitted to the insurer. An extract along with the data concerning the insured event are issued by the medical institution or the physician who provided the medical care.

6.11 If the insured person has been treated by a medical institution or physician who is not the insurer's partner, the insurer has the right to indemnify the provided health service on the basis of the average market price unless otherwise prescribed in the insurance contract.

6.12 If an insured event lasts longer than the term of the insurance contract, the insurer will also indemnify the expenses incurred within 14 days of the end of the insurance period.

6.13 The insurer pays the insurance indemnity to the medical institution or physician on the basis of the treatment invoices submitted by them and in accordance with the contract entered into between the insurer and medical institution or physician.

6.14 If continuing with the treatment is medically not justified, the insurer has the right to reduce the insurance indemnity or refuse to pay the indemnity.

6.15 The insurer has the right to deduct from the insurance indemnity the instalments not paid for the insurance period.

7 General exclusions and release of the insurer from their obligation to perform the contract

7.1 An insured event is not deemed to include the following events or damage arisen as a result thereof:

7.1.1 damage that is directly or indirectly caused by a terrorist act or the preparation thereof. A terrorist act is such an organised violence or a threat to use violence for political, religious, ideological or ethnic purposes that is committed by a person or a group of persons who act(s) in the name of (an) organisation(s) or government(s), according to their instructions or in cooperation with them, in order to influence the government and/or threaten the society or any part thereof;

7.1.2 damage caused by any military event, internal disturb¬ance, acts of state and local authorities, amendment to laws and other legislative acts, natural disasters, pandemics or epidemics (large-scale spread of infectious diseases of which a state authority has notified);

7.1.3 damage caused by direct or indirect harmful effect of radioactive radiation, electromagnetic, light or thermal radiation;

7.1.4 damage caused by participation in an act punishable pursuant to criminal procedure, by an attempt to commit such an act or committing thereof, lawful detention of offenders or while staying at a custodial institution;

7.1.5 damage intentionally caused by the policyholder or insured person;

7.1.6 expenses related to the treatment of an illness or trauma that occurred before the entry into force of the insurance contract unless otherwise agreed in the insurance cont-

ract;

7.1.7 damage that has not arisen in the territory agreed in the insurance contract;

7.1.8 accident caused by mental, psychic or consciousness disorders of the insured person;

7.1.9 damage caused by the insured person as a result of using alcohol, narcotic or other intoxicating substances, or due to diagnostics or treatment of a health disorder resulting from the use of alcohol, narcotic or other toxic substances, psychic diseases or their syn¬dromes, and as a result of treatment of alcoholism, drug addiction, substance dependence, sexually transmitted diseases, etc.;

7.1.10 damage resulting from treatment that was not necessary for direct treatment of the disease, such as aesthetic enhancement and cosmetic surgery;

7.1.11 damage caused to medical assistive devices in constant use, such as spectacles, lenses, prosthetic appliances, hearing aid, wheelchair, crutches;

7.1.12 non-traditional diagnostics or treatment or self-treatment with one's own methods, participation in a clinical trial;

7.1.13 expenses from which the insured person is relieved under the legislative acts in force;

7.1.14 use of services provided without medical indications or if the insured person refused medical care or surgery, and therefore further damage was caused to their life or health;

7.1.15 damage arisen in connection with participation of the insured person in the international operations of the Estonian armed forces, enrolment or participation in the active service, incl. activities in the Defence League, participation in military operations and exercises;

7.1.16 damage arisen from driving a vehicle by the insured person without the right to drive a vehicle of the corresponding category or by violating the Traffic Act in any other manner;

7.1.17 expenses incurred due to such trauma or bodily injuries that have been received as a result of engagement in high-risk sports or hobbies, also competitive sports or relevant training. High-risk sports or hobbies include motor sports, incl. participating as a driver or passenger in motor vehicle races and test drives, bungee jumps, boxing, mountaineering, downhill and speed skiing, flying aircraft without an engine, skydiving and other extreme sports, any professional sports and other sports and hobbies involving similar risks;

7.1.18 damage arisen during professional flights as a pilot of an aircraft or any other member of the cabin crew;

7.1.19 damage arisen in connection with treatment or diag¬nostics of infections with a predominantly sexual mode of transmission (syphilis, gonococcal infection, sexually transmitted chlamydial diseases, chancre, granuloma inguinale, donovanosis, trichomoniasis, anogenital herpesviral infections), AIDS and HIV;

7.1.20 expenses related to sexual pathology, its treatment and diagnostics;

7.1.21 expenses of genetic and cytogenetic testing, except when related to an insured event;

7.1.22 expenses of diagnostics and treatment of psychiatric diseases or their syndromes;

7.1.23 expenses related to speech therapy, ergotherapy or sleep therapy;

7.1.24 expenses of osteoporosis testing;

7.1.25 expenses related to family planning, contraceptive devices and drugs, infertility treatment, artificial insemination, termination of pregnancy without medical indication;

7.1.26 expenses related to transplantation of organs and tissues or haemodialysis upon chronic renal insufficiency unless otherwise agreed in the insurance contract;

7.1.27 expenses of food supplements, dietary cocktails and food for particular nutritional uses, photodynamic laser treatment and informative lectures;

7.1.28 stay at a sanatorium and treatment provided there, accommodation at a sanatorium or spa for the purpose of nursing;

7.1.29 expenses related to trichology or podometry;

7.1.30 treatment services provided by a geneticist;

7.1.31 treatment provided by a medical institution, physicist or nurse that is not registered in the register of the Health Board;

7.1.32 medical care provided by a physicist or nurse who is a close relative to the insured person (child, parent, sister, brother, spouse) (except emergency care);

7.1.33 damage and medical treatment expenses that are indemnified by compulsory insurance (e.g. motor third party liability insurance) payments;

7.1.34 ambulance call-out and transportation of the person by ambulance to a hospital;

7.1.35 treatment received by family members of the insured person who are not specified by name in the insurance contract;

7.1.36 additional expenses related to selection of a physician needed to perform a surgery;

7.1.37 nursing care expenses supported from social assistance unless otherwise agreed in the insurance contract;

7.1.38 suicide attempt and expenses related to suicide.

7.2 The insurer is partially or fully released from the obligation to perform the insurance contract if:

7.2.1 the policyholder, insured person or beneficiary has failed to perform the insurance contract;

7.2.2 the policyholder, insured person or beneficiary has, whether intentionally or due to gross negligence (failure to apply due diligence upon performance of a contractual obligation), failed to perform at least one of the conditions of the insurance contract, which has an impact on the occurrence of an insured event or the amount of damage;

7.2.3 the policyholder, insured person or beneficiary has knowingly supplied incorrect or incomplete data upon entry into an insurance contract or damage handling;

7.2.4 an insured event has occurred due to gross negligence or intent on behalf of the policyholder or insured person. Gross negligence is understood as a situation where the person foresaw or had to foresee the consequences of their act or omission, but recklessly expected that no consequences would arrive due to their conduct or any other circumstances.

8 Application of financial sanctions

Upon entry into and performance of an insurance contract, the insurer will apply financial sanctions. The insurer does not provide insurance cover to any persons or risks or does not indemnify any claims whose insurance or indemnification would be in conflict with trade restrictions, prohibitions or sanctions established by the Government of the Republic, United Nations, European Union, Great Britain or United States of America.

9 Processing of personal data

The insurer processes the data of the policyholder, beneficiary and insured person in compliance with the principles of processing of customer data that have been published on the insurer's website at https://www.ergo.ee/erakliendile/isikuandmete-kaitse. In the principles of processing of customer data, the insurer has provided the customer with all the information that must be provided to the customer pursuant to the EU General Data Protection Regulation.

10 Procedure for settlement of disputes

10.1 The policyholder may turn to a conciliation body at the Estonian Insurance Association to settle a dispute that the policyholder has with the insurer. Before a conciliation procedure, the claim in the disputed matter must be submitted to the insurer and the insurer must be provided with an opportunity to reply to the claim. If the customer is not satisfied with the reply from the insurer, they may turn to an insurance conciliation body (additional information on the website of the Estonian Insurance Association at www.eksl.ee).

10.2 Any disputes arising from insurance contracts (incl. disputes concerning which no agreement has been reached at an insurance conciliation body) are settled in the Harju County Court. The policyholder has the right to file a complaint concerning the insurer's activities with the Financial Supervision Authority.

11 Use of foreign language documents

11.1 Upon agreement between the parties, a translation into a foreign language may be appended to the Estonian-language documents of the insurance contract. The translation has an explanatory meaning only. Upon any inconsistencies between the translation and Estonian-language document, the Estonian-language document prevails.

11.2 If it has been agreed that a foreign-language document (international clauses, etc.) is a part of the insurance contract, the Estonian-language translation of that document will be appended to the insurance contract.