TERMS AND CONDITIONS OF ACCIDENT INSURANCE

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These terms and conditions of accident insurance shall apply to insurance contracts concluded in ERGO Insurance SE, where the insured object is the life and health of the insured person in connection with an accident. In any matters not regulated by these terms and conditions, the parties to an insurance contract shall be guided by the general terms and conditions of ERGO Insurance SE insurance contracts, the Law of Obligations Act and other legislation.

1. Definitions

- **The Insurer** is ERGO Insurance SE.
- **Policyholder** is a natural or legal person who has an insurable interest (in case of a natural person e.g. the insured, a person connected with the insured person; in case of a legal person e.g. the employer, a sports society, etc) and who has concluded an insurance contract with the insurer.
- **Insured person** (hereinafter: the insured) shall mean the policyholder or a natural person who is or is not specified by name in an insurance contract and the insurance risk related to whom is insured. The insured may be a person who is at least 1 year old and is not older than 70 at the conclusion of the contract. The insured may not be a physically or mentally disabled person, who needs care or supervision. A contract concluded on behalf of the said person shall be invalid from inception.
- **Beneficiary** is a natural person determined in the insurance contract by the policyholder upon written consent of the insured. Beneficiary is entitled to the death benefit. If the beneficiary has not been determined by name or the insured is younger than 18, the death benefit shall be paid out to the heir(s) of the insured.
- **Insured event** is an unexpected and unforeseeable event which has taken place during the validity of the insurance contract and on the conditions as agreed in the insurance contract against the free will of the insured, as a result of which an external and/or violent force causes damage to the health of the insured or causes the death of the insured.
- **The sum insured** is the maximum amount of indemnity per one insured person and per one insured event. The sum insured shall be deemed to be the limit of the permanent disability benefit.
- **Deductible** is the amount of money specified on the insurance policy, which shall be borne by the insured upon each insured event.
- **Insurance indemnity** is the amount of money which is paid out after the insured event. The amount of insurance indemnity per insured event shall depend on the damage caused to the insured as a result of the insured event, the contractual limits of benefits and the sum insured. The types of insurance indemnity are medical treatment expenses, daily allowance, trauma benefit, permanent disability benefit and death benefit.

2. Medical treatment expenses

2.1. Medical treatment expenses compensate for reasonable and justified medical treatment expenses resulting from an insured event, which are not compensated for by the Estonian Health Insurance Fund. Medical treatment expenses which were borne within up to one year as of the occurrence of the insured event shall be compensated for. Medical treatment expenses are compensated on the basis of invoices delivered by a state or municipal medical institution, private medical institution or rehabilitation centre registered in the Republic Of Estonia. If the person does not have a compulsory medical insurance of the Estonian Health Insurance Fund, the insurance indemnity shall be calculated similarly with those who are covered by health insurance of the Estonian Health Insurance Fund.

2.2. The following shall be compensated for:

2.2.1. costs of essential examination and treatment provided and/or prescribed by a physician (incl. necessary and reasonable costs of medicaments), except for costs of psychotherapy;

2.2.2. reasonable costs of physiotherapy and medically prescribed physical training, which are necessary from the treatment perspective and prescribed by a physician; massage costs are compensated for a maximum of ten sessions per one insured event; the cost of medical physical training is compensated for in full;

2.2.3. reasonable costs of purchasing or renting medical aids, necessary from the treatment viewpoint;

2.2.4. costs for repairing and re-acquiring glasses, hearing aids, prostheses, used by the insured and damaged or lost as a result of an insured event;

2.2.5. reasonable costs for the treatment of tooth injuries caused by an accident (incl. replacement cost of teeth);

2.2.6. reasonable and necessary costs of plastic surgery.

3. Daily allowance

3.1. Daily allowance is paid if as a result of an insured event the temporary incapacity for work of the insured lasts for more than seven days.

3.2. Daily allowance is paid for every treatment day while on sick leave, no matter whether it is inpatient or outpatient treatment. Daily allowance is paid also if the incapacity for work of the insured has been determined with the decision of a medical assessment committee.

3.3. The amount of daily allowance shall be the percentage of the daily wages of the insured agreed upon with the insurance contract or a specific amount determined in the insurance contract.

3.4. The daily wages shall be calculated on the basis of the net income of the insured.

3.5. Net income shall be the taxable income, received by the insured during the 12 calendar months immediately preceding the occurrence of the insured event, from which the taxes payable under the law have been withheld.

3.6. To calculate the daily wages, the net income of the insured shall be divided by the number of calendar days in the 12 months immediately preceding the occurrence of the insured event. If the insured has received net income for a shorter period than 12 calendar months during the time immediately preceding the insured event, the actual income during the said period and the duration of the time corresponding to the same, shall be taken into account.

3.7. If at the time of occurrence of the insured event the insured is an entrepreneur, the net income shall be their income taxable with social tax, declared on their income tax return for their last calendar year. If at the moment of occurrence of the insured event the insured has been an entrepreneur for less than one calendar year, the net income shall be calculated on the basis of income during the period of entrepreneurship and the duration of this period in calendar days.

3.8. If the insured has not received net income during the 12 months preceding the insured event, the daily allowance shall be calculated on the basis of monthly minimum salary valid at the moment of occurrence of the insured event.

3.9. In case of a dispute, the amounts declared to the Tax and Customs Board shall be taken as the basis.

3.10. Daily allowance shall be paid within up to one year as of the day of the insured event.

3.11. The payment of daily allowance will be terminated as of the day, on which:

3.11.1. the insured commences work;

3.11.2. the period of incapacity for work indicated on the certificate of incapacity for work or the period of incapacity for work determined with the decision of a medical assessment committee ends;

3.11.3. the insurer decides permanent disability benefit to the insured.

4. Trauma benefit

4.1. The insurer shall pay trauma benefit, if as a consequence of an insured event the insured suffers temporary mental or physical damage to health, the treatment of which lasts at least for seven days. The duration of treatment must be evidenced by a medical institution. The requirement for the duration of treatment shall not apply to a fracture that is proven with an X-ray.

4.2. Trauma benefit is a single benefit, the percentage of which is determined on the basis of the table of trauma benefit and permanent disability benefit (hereinafter the compensation table) that was in effect at the beginning of the insurance period, pursuant to the maximum limit of trauma benefit agreed upon in the insurance contract. If the consequence of the insured event is not included in the compensation table, the decision on indemnity shall be made based on the severity of the injury.

4.3. If the insured is entitled to the indemnity on the basis of more than one clause of the compensation table, the said indemnities shall be summed up in a way that the consolidated indemnity shall not exceed the maximum limit of trauma benefit agreed upon in the insurance contract.

5. Permanent disability benefit

5.1. If the insured event causes permanent mental or physical damaged to health i.e. disability to the insured, to be determined according to these terms and conditions, the insurer shall pay permanent disability benefit. A disability is permanent, if the functioning of a part of the body or sensory organ has not rehabilitated within one year as of the occurrence of the insured event in order to guarantee normal functioning of the part of body or sensory organ.

5.2. The existence and extent of permanent disability shall be determined by a medical expert of the insurer after one year has passed from the insured event, taking as a basis the state of health of the insured at the time of determining the disability. If the injury is permanent and there is no hope of improvement, permanent disability and the extent thereof may be determined before one year has passed. Permanent disability benefit is not paid, if permanent disability appears later than one year after the accident. If the state of health of the insured deteriorates after determining the permanent disability, no additional permanent disability benefit will be paid.

5.3. Permanent disability is determined on the basis of medical documents and the indemnity is paid as a percentage of the agreed limit of permanent disability benefit.

5.4. The percentage of the permanent disability is determined on the basis of the compensation table that was in effect at the beginning of the insurance period. If the damage to a body part or sensory organ, caused as a result of the insured event, cannot be determined on the basis of the said compensation table, the decision on indemnity shall be made on the basis of severity of the permanent disability.

5.5. When determining the permanent disability, only the severity and nature of the disability are concerned and not the job, hobbies, lifestyle, etc. of the insured. When determining the disability, the degree of disability determined by the state and/or loss of capacity for work or decreased income shall not be taken into account.

5.6. If as a result of the insured event the functioning of more than one body part or sensory organ is damaged, a consolidated indemnity shall be determined, which shall not exceed the limit of permanent disability benefit.

6. Death benefit

Death benefit is paid, if the insured has died as a result of the insured event within three years as of the day of the insured event.

7. Validity of insurance cover in case engaged in sports and high risk jobs

7.1. When engaged in sports, the insurance cover shall apply without a special agreement, except for competitive sports and relevant training or if engaged in sports, listed in clause 7.3.

7.2. The insurance cover shall apply in competitive sport and the relevant training only if it has been agreed upon in the insurance contract. Competitive sport is the sport, the purpose of which is achieving success in a public sporting competition. Public sporting competition means participation in series, cup and league competitions, in Estonian Championships and international competitions and preparations for these competitions.

7.3. Insurance cover shall not apply if engaged in the following sports (incl. training and competitions): aerial sport (including bungee and parachute jumps), boxing (including kickboxing, Thai boxing, etc.), alpinism and other types of mountain climbing (except for mountain hiking), speed and downhill skiing, alpine skiing on slopes without trails or outside ski trails, rafting.

7.4. The insurance cover applies to working in a high-risk position only, if it has been agreed upon in the insurance contract, except for the areas of activity/positions listed in clause 7.5. High-risk positions shall include car or bus drivers, builders, operational employees (e.g., policemen, rescue workers, firemen, etc.), chimney-sweeps or any other persons working at high altitudes, diver, miners or other mine worker, professional sportsmen, members of a ship crew, border guards, security guards, collecting agents, stuntmen, circus artists, handlers of combustive substances or producers of crude oil.

7.5. Insurance cover shall not apply to a crew member of any aircraft or while performing high-risk tasks in defence forces, when being in compulsory or active service or on a military mission.

8. General exclusions

8.1. The following shall not be compensated for:

8.1.1. events caused by a stroke, epilepsy or other convulsions;

8.1.2. events, caused by the use of nuclear energy for any purpose or its exit from control or from radioactivity, terrorism, war, civil war, invasion, any armed conflict, mass disorder, civil unrest, revolution, coup d'état, strike, confiscation, seizure or lockout;

8.1.3. damage to health, caused by treatment, incl. surgical treatment, except for if the need for treatment resulted from the insured event;

8.1.4. bacterial infections, except for tetanus, rabies and other infections spreading through the wound caused by an insured event;

8.1.5. infection with HIV, AIDS or B or C hepatitis;

8.1.6. changes in spine curvature, internal or cerebral haemorrhage, abdomen or inguinal hernia, except if these are caused by the insured event;

8.1.7. poisoning, caused by voluntarily taken solid or liquid substances (poisoning with alcohol or any other narcotic substances, food poisoning, salmonella, dysentery, etc.);

8.1.8. mental illness or mental disorder confirmed with a diagnosis of a physician and the related injuries;

8.1.9. attempted suicide or suicide;

8.1.10. events, which have occurred to the insured while being imprisoned in a detention facility;

8.1.11. treatment costs, which shall be compensated under the law or under other compulsory insurance.

9. Obligations of the policyholder, insured and beneficiary

9.1. The policyholder has the obligation:

9.1.1. upon entering into an insurance contract to notify the insurer of all substantials known to the same, which have an impact on the insurer's decision to conclude the insurance contract or to do so on the agreed additional conditions;

9.1.2. to explain the rights and obligations arising from the insurance contract to the insured person(s) and beneficiary/beneficiaries.

9.2. The policyholder and/or the insured shall immediately notify the insurer of an increase in the insurable risk (e.g. if the insured commences work in a high-risk position, engages in competitive sport, etc.).

9.3. The insured has the obligation:

9.3.1. to make its best efforts to avoid an insured event and reduce any potential damage, not to increase the insurable risk and to prevent third parties from increasing it;

9.3.2. upon occurrence of an insured event, to see a physician at the first possibility, follow the prescriptions of the physician and make best efforts to avoid increase of damages caused by the insured event; to notify the insurer at the first opportunity in writing of the occurrence of the insured event either personally or via other persons, by presenting data in the application on the event and the estimated time of treatment, and follow hereafter the instructions of the representative of the insurer; in case of bodily injury caused by third parties to inform the police thereof either in person or via other persons; upon request of the insurer and during the time as determined by the same to pass a medical check at the physician designated by the insurer; to ensure that the insurer receives the necessary information, explanations and documents, authorising the insurer to apply for these or submit these personally at the proposal of the insurer.

9.4. If the insured event has caused death of the insured, the policyholder and/or the beneficiary shall notify the insurer at the first possibility after learning of the death of the insured. The insurer shall be notified even if they have already been notified of the insured event. The insurer has the right to request the presence of a physician, appointed by the insurer, during autopsy of the insured.

9.5. The obligation to supply proof on the insured event is borne by the policyholder, insured or beneficiary. The said person shall furnish to the insurer the information that is necessary for determination of the performance of the contractual obligations of the insurer.

10. Compensation procedure

10.1. Daily allowance, trauma benefit and/or permanent disability benefit shall be paid to the insured, medical treatment expenses compensated for directly to the medical institution or the insured. Death benefit shall be paid to the beneficiary.

10.2. The insurer has the right to verify the accuracy of the presented information and request documents evidencing the insured event.

10.3. The insurer has the right to set off its obligation to perform the insurance obligation against the insurance premiums that have not been paid under the insurance contract until the end of the insurance period.

10.4. Any insurance indemnity paid previously under the same insured event shall be deducted from the death benefit. If the previously paid insurance indemnity is higher than the death benefit, the already paid insurance indemnity will not be reclaimed.

10.5. Any insurance indemnity paid previously under the same insured event shall be deducted from the permanent disability benefit. If the previously paid insurance indemnity is higher than the permanent disability benefit, the already paid insurance indemnity will not be reclaimed.

10.6. If the occurrence of the insured event or its consequences were influenced by previous and/or current illnesses or bodily injuries or the duration of treatment was not medically justified, the insurer will have the right to reduce the payable insurance indemnity or to refuse payment of the indemnity.

11. Release of the insurer from the obligation to perform the insurance contract

11.1. The insurer shall be partially or fully exempted from the obligation to perform the insurance obligation if:

11.1.1. the policyholder, insured or beneficiary has not met at least one of the requirements specified in clause 9;

11.1.2. the policyholder has not paid the insurance premium by the agreed due date (in case of the periodic premiums at the latest by the due date as further specified by the insurer) and if the insured event occurs after the agreed due date for payment of the insured event;

11.1.3. the policyholder, the insured or the beneficiary has intentionally or due to gross negligence (to a substantial extent, failure to apply the care required for performance of a contractual obligation) violated at least one of the conditions of the insurance contract, which has an impact on the occurrence of the insured event or the amount of damage;

11.1.4. the policyholder, the insured or the beneficiary has misled or tried to mislead the insurer with regard to the circumstances of occurrence of damage and/or the amount thereof, or has attempted to deceive the insurer otherwise with regard to the circumstances of the insurance contract or its performance;

11.1.5. the insured event has occurred due to gross negligence or indent of the insured. Gross negligence is understood as a situation where a person foresees the consequences of their behaviour, but recklessly expects that no consequences will arise;

11.1.6. the insured event is causally related to the consumption by the insured of alcoholic, narcotic, toxic, psychotropic or other intoxicating substances;

11.1.7. the insured event has occurred in connection with a crime committed or attempted by the insured.

11.2. The extent of exemption from the obligation to perform the insurance contract shall be decided by the insurer.