Triglav osiguranje a.d.o.
Milutina Milankovića 7a
11070 Novi Beograd

triglav

General terms and conditions of voluntary health insurance

OU-DZO 20-03

INTRODUCTORY PROVISIONS
Article 1

These General Terms and Conditions of Voluntary Health Insurance (hereinafter referred to as the General Terms and Conditions) constitute an integral part of the Agreement on Voluntary Health Insurance (hereinafter referred to as the Insurance Agreement) that the Policyholder voluntarily concludes with insurance provider Triglav osiguranje, which organizes and implements voluntary health insurance (hereinafter: insurer).

These general terms and conditions regulate the rights and mutual obligations of the parties in the procedure of offering and contracting voluntary health insurance, the duration of insurance, general provisions on insurance premium, as well as the conditions under which certain rights are exercised, the scope of insurance coverage and other issues of importance for voluntary health insurance.

DEFINITIONS
Article 2

The meaning of certain expressions in the General Terms:

1. **Insurance provider (hereinafter: Insurer)** - Triglav osiguranje a.d.o. Belgrade, which in accordance with the law organizes and implements voluntary health insurance;

2. **Voluntary Health Insurance Policyholder** - is a legal or natural person, as well as another legal entity that concludes a Voluntary Health Insurance Agreement with the Insurer in the name and on behalf of the Insured, i.e. in its own name and on behalf of the from its own funds or the funds of the Insured;

3. **Insured** - a natural entity who concludes the Agreement on Voluntary Health Insurance or, on whose behalf, and with the consent of whom, the Agreement on Voluntary Health Insurance is concluded with the Insurer, and who exercises the rights set forth in the Agreement on Voluntary Health Insurance, as well as a family member of the Insured who is included in a voluntary health insurance contract;

4. **Family members** - are spouses or extramarital partners, children (born in wedlock, out of wedlock and / or adopted or supported stepchildren and children) of the Insured persons who are legally dependent persons up to 18 years of age, i.e. up to 26 years of age in case they are in full-time studies;

5. **Newly insured person** - is a person who is included in the voluntary health insurance for the first time with the Insurer or has not been insured continuously until the day of the beginning of the Insurance Contract;

6. **Insurance coverage** - implies the agreed basic insurance coverage, and it also implies additional insurance coverage if contracted separately and paid additionally;

7. **Offer** - The contract on voluntary health insurance is concluded on the basis of a preceding proposal for concluding a contract on voluntary health insurance (hereinafter: the offer) given by the insurer to the person wishing to conclude a contract on voluntary health insurance.

8. **Insurance Policy** - a document on concluded Agreement on Voluntary Health Insurance with the Insurer;

9. **Insurance Premium** - the amount of money paid by the insured person or the policy holder to the Insurer on the basis of the concluded contract on voluntary health insurance

10. **Health service provider** - Health service provider is a health institution, i.e. private practice or other legal entity and entrepreneur with which the Insurer has concluded a contract for the provision of health services covered by the contract on voluntary health insurance.

11. **Network of health care institutions** - are health care institutions, private practice and other health care providers, which have a contract with the Insurer on the provision of health care services, where the insured person uses services contracted by the policy and in the manner prescribed by these conditions; The network of health care institutions is published on the Insurer's website.

12. **Participation** - Obligatory participation of the Insured in the costs of contracted health services.
    1. The participation in the costs is calculated on the maximum amount covered if the cost of medical services is either equal to or higher than the limit, i.e. at the amount of medical service if this amount is lower than the limit.
    2. If participation in the costs is agreed, the limit defined by the policy is reduced by the amount of the insured's participation;

13. **Medicine** - a product which has been approved to be put on the market within the Republic of Serbia, as well as a product that has not been approved to be put on the market within the Republic of Serbia and which is imported on the basis of the approval of the Agency for Medicines and Medical Devices of Serbia, in accordance with the law that regulates the area of medicines;

14. **Medical-Technical Aids** - medical devices used to functionally and aesthetically replace missing parts of a body, or used to provide support, prevent deformities and correct the existing deformities, and to facilitate the performance of basic life functions;

15. **Implants** - medical aid which is surgically implanted into a human body;

16. **Financial recompense** - recompense for the insured in case of loss of income or salaries or other earnings due to temporary work-related hindrance, transportation costs related to the use of health care, and other types of financial benefits related to the exercise of rights from voluntary health insurance

17. **Insured sum** - the amount of compensation representing the max-

imum liability of the Insurer according to the concluded insurance contract

18. **Insured event** - a future event, which is uncertain and independent of the will of the contractor, i.e. the insured, which initiates an obligation for the Insurer to pay insurance compensation.

19. **Waiting period** - the period of time during which the Insurer's obligation is excluded should the insured event occur, regardless of the fact that the insurance contract is in force.

20. **A document on voluntary health insurance** - The document which is issued by the Insurer to the insured, on basis of which the insured proves the status of the insured person under the voluntary health insurance and exercises rights from voluntary health insurance.

21. **Special terms and conditions** - terms and conditions which regulate the rights and obligations of the contracting parties for a specific type or combination of types of voluntary health insurance, which form an integral part of the insurance contract (hereinafter: special conditions);

GENERAL PROVISIONS
Article 3

By the Insurance Agreement, the Insurance Policyholder undertakes to pay the premium to the Insurer, and the Insurer undertakes, should the insured event occur, to compensate for the treatment costs or pay out pecuniary compensation in accordance with these General Terms and Conditions, Special Terms and Conditions and the Agreement on Voluntary Health Insurance.

All the notices and reports that the Parties are required to provide, if made orally, over the phone or otherwise, must be confirmed in writing.

The date of receipt of the notice, i.e. the report referred to in paragraph 2) of this Article, shall be deemed the day when the Insurer receives the notice or the report, or the date indicated in the Insurer's registry and the and stamp on the received notification or report.

Agreements that are related to the contents of the Voluntary Health Insurance contract shall be valid only if concluded in writing.

TYPES OF INSURANCE
Article 4.

The types of voluntary health insurance that the Insurer provides:

1. Parallel health insurance - insurance that covers the costs of health care that arise when the insured person supplements the rights from the compulsory health insurance in terms of content, scope and standards;

2. Supplemental health insurance - insurance that covers the share in the costs of health care, i.e. covers the costs of health services, medicines, medical devices, or cash compensations that are not covered by the rights from the compulsory health insurance;

3. Private health insurance - insurance of persons not covered by compulsory health insurance, to cover the costs of the type, content, scope and standard of rights contracted with the insurer.

The insurer may organize and implement all types of voluntary health insurance referred to in paragraph 1 of this Article, as well as a combination of types of voluntary health insurance referred to in paragraph 1 of this Article.

ACQUISITION OF INSURANCE PROPERTIES
Article 5.

The status of an Insured under the parallel, i.e. supplemental voluntary health insurance may be gained by a person who has obtained the status of an insured under the mandatory health insurance, and who expresses a clear intention to conclude the Agreement on parallel or supplemental voluntary health insurance with the Insurer, in accordance with the general and special conditions of the Insurer.

The status of the Insured in private voluntary health insurance may be gained by a person who is not insured by the mandatory health insurance, and who expresses a clear intention to conclude the Agreement on private voluntary health insurance with the Insurer, in accordance with the general and special conditions of the Insurer.

The members of the family of the Insured can also become insured, in accordance with the Special conditions of the insurer.

CONCLUDING THE AGREEMENT
Article 6.

The contract on voluntary health insurance is concluded on the basis of a preceding offer for concluding a contract on voluntary health insurance (hereinafter: the offer) given by the insurer to the person wishing to conclude a contract on voluntary health insurance.

The offer contains important information on the contracting parties, i.e. persons insured under the voluntary health insurance, the beginning date of insurance, waiting period, as well as ending date of insurance, amount and deadlines for payment of insurance premium, maximum agreed amounts by covered risks and other important elements for insurance contracting.

Important data on the contracting parties, i.e. insured persons of voluntary health insurance referred to in paragraph 2 of this Article are:

1) for a natural person:

(1) name and surname, as well as the date of birth of the in sured person of voluntary health insurance,

(2) PIN, i.e. registration number for foreign citizens,

(3) address of permanent or temporary residence in the Re public of Serbia (street and number, place and municipality),

(4) contact (telephone number or e-mail address);

2) for a legal entity:

(1) name, i.e. business name,

(2) VAT number and registration number,

(3) seat address (street and number, place and municipality),

(4) contact (telephone number or e-mail address).

In case that the Agreement on Collective Insurance is to be concluded, the Policyholder may submit an offer which contains data on each individual person who wants to be insured.

The offer referred to in the previous paragraph of this Article shall contain data on each individual person covered by the collective insurance, as follows:

1) name and surname, as well as the date of birth of the person insured under the voluntary health insurance;
2) PIN, i.e. registration number for foreign citizens;
3) address of residence, i.e. stay in the Republic of Serbia (street and number, place and municipality) of the insured person of voluntary health insurance or the contractor, i.e. the seat of the contractor;
4) contact (telephone number or e-mail address).

The offer referred to in paragraph 1 of this Article shall, as important data, also contain data on the previous health condition of the insured person of the voluntary health insurance, which are necessary for the insurer to assess the insurance risk.

Multiple insurance by one policyholder under one policy can be contracted only on condition that all insured persons have the same coverage level.

The proposal must state accurately, truthfully and completely all the information necessary for the conclusion of the insurance contract, as well as all the facts that are of significance for the risk assessment.

The insurer may request from the potentially insured person additional information on the health condition, i.e. it may request the insured to submit documentation (medical or laboratory reports, findings, etc.), or if necessary to perform a medical examination.

The insurer performs a risk assessment for each insured person, that is, he / she has the right to accept the person for whom he / she determines that he / she presents an increased risk, but with changed insurance conditions, i.e. to increased premiums or changed amount or volume of coverage. Provisions that specify the increased risks are contained in the Special Conditions of the Insurer.

The obtained health data on a possible insured person cannot be a reason for refusing admission to insurance, but are used by the Insurer to assess the risk in order to calculate the insurance premium.

By signing the offer, i.e. the policy, the Insured, i.e. the Insurance Contractor confirms the acceptance of the General and Special Terms Conditions.

The insurer issues the policy as proof of the concluded insurance contract and compiles it in at least two copies, one of which is retained by the policyholder, i.e. the insured of voluntary health insurance, and the other is retained by the insurer, i.e. the authorized representative of the insurer.

Notwithstanding paragraph 1 of this Article, the insurer may issue a coverage list.

The policy, i.e. the coverage list contains:

1) name and surname of the insured person of voluntary health insurance or the contractor, i.e. the business name of the contractor;

2) date of birth of the insured person of voluntary health insurance;

3) permanent or temporary residence and residential address of the insured person of the voluntary health insurance or the contractor, i.e. the seat of the contractor;

4) PIN, i.e. registration number for foreign citizens, i.e. VAT number and registration number of the contractor;

5) name and address of the insurer;

6) insurance coverage;

7) the amount and risk of insurance;

8) the amount of the premium, the manner and conditions of payment of the premium;

9) reference to the tariff at which the premium was calculated;

10) number of the policy, i.e. list of coverage;

11) number of the offer for concluding a contract on voluntary health insurance;

12) the day of the beginning of the insurance, the waiting period of the insurance and the validity period of the insurance, i.e. the policy or the list of coverage;

13) signature of the authorized person with the insurer;

14) signature of the contractor of voluntary health insurance;

15) place and date of issuance of the policy, i.e. list of coverage;

16) other data in accordance with the law.

In addition to the data from the previous paragraph, in the case when a contract on voluntary health insurance is concluded for the use of health care of the insured of voluntary health insurance during the stay abroad, the policy, i.e. the coverage list also contains the passport number of the insured, the name of the issuing authority and the dates of issue and validity of that passport.

DURATION OF THE INSURANCE CONTRACT
Article 7.

According to the General Conditions, the insurance contract is concluded for a period that cannot be shorter than 12 months counting from the date of conclusion of the contract.
Notwithstanding paragraph 1 of this Article, voluntary health insurance may last shorter, as follows:
1) during the stay of the insured person of voluntary health insurance abroad, i.e. to cover the costs of health care provided abroad;
2) in the case when the capacity of the insured person in the system of compulsory health insurance lasts for a shorter period;
3) during a temporary stay in the Republic of Serbia of a voluntary health insurance insured person who is a foreign citizen or a stateless person;
4) for persons who have acquired the basis for insurance under collective agreements during the agreed insurance period;
5) if the issuance of the insurance policy is preceded by the conclusion of the coverage list.

Article 8.

The insurer's obligation shall begin on the twenty-fourth hour of the day which is in the policy stated as the beginning of insurance, but not before the date when the premium is paid, or the first instalment of the premium is paid, unless otherwise specified in the policy or in special terms.

It is also considered that the first contracted premium is paid if the policy holder or the insured has given a written statement on the basis of which the premium is collected through the suspension of his salary.

If the first contractual insurance premium is not paid until the date indicated in the policy as the commencement date of the insurance period, the Insurer's obligation shall begin on the twenty-fourth hour of the day when the first agreed premium is paid in entirety.

If the waiting period is agreed, the Insurer's obligation shall begin on the twenty-fourth hour of the day which is specified as the expiration date of the waiting period, provided that the insurance premium has been paid.

Article 9.

The insurance contract shall terminate for each individual insurer within 24.00 hours period regardless of the agreed duration in the case of:
- death of insured person – on the day of death;
- loss of the status of the insured person in compulsory health insurance - the day of losing the status;
- in the case of private health insurance - obtaining the status of a mandatory insured person, on the day of receiving the status
- failing to perform the payment of premium;
- in other cases, in accordance with the regulations, General and special terms and conditions of the Insurer.

WAITING PERIOD (WITHDRAWAL PERIOD)
Article 10.

An insurance contract may define a withdrawal period or the period of time in which the Insurer has no obligation to pay compensation if the insured event occurs.
The withdrawal period shall be calculated from the beginning of the

insurance specified in the policy, provided that by that date the first agreed premium has been paid.
If the due premium is not paid until the beginning of the insurance, the withdrawal period is calculated from the expiration of the 24: 00 hour of the day when the first agreed premium is paid.
Waiting periods do not apply in case of a renewal of an insurance contract.

INSURANCE PREMIUM
Article 11.

The amount of premium is determined by the Insurer in accordance with the premium tariff (hereinafter: tariff) and regulations governing the area of voluntary health insurance.

The Insurer may not increase the premium during the term of the Agreement on voluntary health insurance.

Exceptionally from paragraph 2) of this Article:
1) in case of Agreements concluded for a period of several years, the premium may be changed after expiry of a 12-month period from the date of concluding the Insurance Agreement, i.e. every 12 months until expiry of the term of the Insurance Agreement concluded.
2) in the event that, when concluding the contract on voluntary health insurance, the contractor or the insured withheld circumstances important for the risk assessment.

Should the amount of insurance premium raise, in accordance with these Conditions, the insurer is obliged to notify the contractor in writing, with an explanation, of the increase in the amount of premium at least 30 days before the end of the current insurance year.

The policy holder is required to duily pay the premium, within the deadlines determined by the contract or the insurance policy.

When the policyholder and the insured person of the voluntary health insurance are not the same person, the payment of the premium is borne by the insured person only if there is his/her written consent.
If it is agreed that the annual premium is paid in semi-annual, quarterly or monthly instalments, the Insurer shall be entitled to an insurance premium for the entire year of the insurance.

Notwithstanding paragraph 5 of this Article, in the event of termination of insurance due to the death of the insured, the Insurer shall be entitled to the premium until the day the insurance is effective.

The insurer has the right to charge a legal default interest to the policy holder for each day of exceeding the deadline in which he is required to pay the due insurance premium.

The first agreed insurance premium, i.e. the first instalment of the premium, is due before the start of the insurance contract.

Each subsequent instalment of insurance premium is due on the last day of the current time period (semi-annual, quarterly, monthly) and is valid for the following period of time.

Payment of outstanding premium instalments always refers to the first unpaid premium and the Insurer has the right to charge for the outstanding premiums and interest on instalments on any reimbursement under the contract.

The insurance premium shall be recognized as paid on the day when the payment is recorded on the Insurer's account.

If the policyholder does not pay the due insurance premium, i.e. the installment of the insurance premium, the insurer's obligation to cover the costs, i.e. part of the costs for the provision of health services covered by the voluntary health insurance contract, i.e. the policy, expires within 30 days of handing in the written notice of outstanding insurance premiums.

After the expiration of the period referred to in paragraph 1 of this Article, the insurer may terminate the contract on voluntary health insurance without a subsequent notice period and initiate the procedure of collection of due premiums with the corresponding interest before the competent court.

The insurer is required to accept the payment of the insurance premium made by any person having a legal interest in paying the insurance premium.

A DOCUMENT ON VOLUNTARY HEALTH INSURANCE
Article 12.

On the day of issuing the insurance policy, and at the latest within 60 days, the insurer is required to issue to each insured a document on the basis of which the rights from voluntary health insurance (hereinafter referred to as: document) are exercised.

The document referred to in paragraph 1 of this Article shall contain the following information:
1) business name of the insurer;
2) name and surname, as well as the date of birth of the insured person of the voluntary health insurance;
3) PIN of the insured person of voluntary health insurance, i.e. registration number for foreign citizens;
4) amount of coverage;
5) policy number;
6) validity of the document.

The rights from the voluntary health insurance are exercised on the basis of the document on voluntary health insurance, and exceptionally on the basis of the policy, i.e. the list of coverage until the moment of obtaining the document on voluntary health insurance within the deadline referred to in paragraph 1 of this Article.

In the case when the rights from the voluntary health insurance are exercised directly with the insurer, they are exercised on the basis of the policy, i.e. the list of coverage.
In the case of contracts on voluntary health insurance that are concluded for a period of up to 90 days, the insured person of the voluntary health insurance exercises the rights from the voluntary health insurance on the basis of the policy.

The person insured under the voluntary health insurance is obliged to submit a document, i.e. a policy, i.e. a list of coverage on the basis of which he exercises the rights from voluntary health insurance, to the provider of health services, by which he realizes health care on the basis of a contract on voluntary health insurance.

The document is valid when accompanied by an identity card or other identification document containing a photography of the insured.

The insured is required to report the loss of the document without delay, in writing, to the department of the Insurer performing the activities of voluntary health insurance. In this case, the Insurer is required to issue a duplicate of the document at the additional costs.

RISKS COVERED BY INSURANCE
Article 13.

The insured event is an event where a medically justified treatment (health services, medicines, medical-technical aids, implants, etc.) is carried out for the insured person due to health disorders (illness or injury) and which is the subject of the insurance contract and the expenses of which have to be paid to the health insurance institutions, private practice, other health care provider or insured person.

If an insured event occurs within the scope of these Terms and Conditions, the insurer is required to reimburse the insured for the standard and usual expenses, up to the agreed amount of coverage, which arise during the term of the insurance contract, in connection with a medically justified treatment performed for the insured.

Notwithstanding paragraph 2 of this Article, if the insured event occurred prior to the beginning of the insurance coverage, and the treatment for that insured event also takes place after the beginning of the

insurance coverage, the Insurer is not required to bear the costs incurred due to such treatment.

In any case, the insured event ends with expiry of the insurance contract, in accordance with the General Conditions.

Article 14.

The amount of the insurance coverage, as well as the obligations of the Insurer under the insurance contract are determined by the special conditions of the Insurer.

The insured sum indicated in the insurance policy represents the maximum liability of the Insurer, according to the concluded contract.

The insurance coverage is valid 24 hours a day during the contracted term of the insurance, at the territory of the Republic of Serbia, unless otherwise stipulated by special conditions.

PARTICIPATION OF THE INSURED IN TREATMENT COSTS
Article 15.

The contracting party and the Insurer may define by a contract the participation of the insured in any claim, i.e. the cost of health services, in the appropriate amount or percentage.

In this case, the insured participates in the corresponding percentage or amount in such a way that the amount of the contracted participation of the insured is deducted from the total amount of the Insurer's due liabilities.

If the value of the occurred damage is less than the contracted, the Insurer has no obligations regarding the payment of the compensation up to the amount of the contracted share.

The method of calculating the participation of the insured in the costs of treatment is determined by the special conditions of the Insurer.

The contracted participation of the insured in the damage is applied for each insured event that occurs during the term of the insurance, except in the case of coverage of a systematic medical examination.

OBLIGATIONS OF THE INSURER
Article 16.

The insurer is obligated to enable the Insured to exercise his/her rights provided under the Agreement on voluntary health insurance, as well as the rights defined in these General Terms and Conditions and Special Terms and Conditions.

In line with the Insurance Agreement, i.e. Policy, and Special Terms and Conditions, the Insurer is required to compensate a healthcare service provider or the Insured for treatment costs or a part thereof incurred due to exercising the rights under the contracted voluntary health insurance, as well as the agreed amount of financial compensation, within 14 days as of the date of receival of complete documentation based on which the indisputable existence and scope of liability can be established.

The insurer is obliged to timely provide the insured under the voluntary health insurance with all the information, as well as the necessary documentation, which are related to the implementation of voluntary health insurance and which are important for exercising the rights arising from voluntary health insurance, as well as information with which health care providers can exercise rights from voluntary health insurance, except for information that present a trade secret.

The Insured Sum specified in the Policy represents the top limit of the Insurer's obligation under the Insurance Agreement.
The Insurer is entitled to request from the Insured, Policyholder or any other legal or physical entity to provide additional explanation or additional documentation in order to establish important circumstances relevant for the reported Insured Event.
The Insurer is entitled to refer the Insured to a control medical examination or additional medical evaluation, by which necessary circumstances relevant for the reported insured event would be established. The costs of such examination are borne by the Insurer.

EXCLUSIONS OF THE INSURER'S OBLIGATION
Article 17.

The insurer is not obliged to pay the insurance indemnity in the following circumstances:

- if the insured gave incorrect and false information on purpose, or concealed important circumstances of significance for the conclusion of the insurance contract,
- if the contracting party, or the insured person does not pay the premium for the insurance until the agreed deadline, nor it is done on his behalf by another person,
- in the event of abuse of the insurance policy or document,
- If the volume of contracted health services and the amount of their costs is exceeded,
- If the claim is based on false data and false documentation,
- If the subject of the claim is the cost of organizing and implementing the preventive programs of vaccination, immunoprophylaxis and chemoprophylaxis,
- for reimbursement of health care costs and payment of benefits covered by compulsory health insurance, except for private health insurance.

OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED
Article 18.

In addition to the obligations stipulated by the regulations governing the field of voluntary health insurance and General and special conditions of the Insurer:

1. when realizing the rights from voluntary health insurance, at a medical institution, private practice or other health care provider, the insured person is required to provide the document;

2. the insurance policyholder, or the insured, is required to inform the Insurer within the shortest reasonable time about any changes in the data about the insured persons (such as changing the address, occupation or marital status, termination of employment, etc.) or any other important changes such as the change in the number of insured persons, which involve the correction of the insurance risk assessment.

TERMINATION OF INSURANCE AGREEMENT
Article 19.

The insurer may not terminate the contract on voluntary health insurance before the expiration of the term for which the contract was concluded.
Notwithstanding paragraph 1 of this Article, the insurer may terminate the contract on voluntary health insurance before the expiration of the term for which the contract was concluded in the case of:

1) failure to pay the agreed insurance premium;
2) termination of the capacity of the insured person in the system of compulsory health insurance, for the person insured under the voluntary health insurance, during the contract on supplementary, i.e. additional voluntary health insurance;
3) in other cases provided by law.

If the policyholder does not pay the due insurance premium, i.e. the installment of the insurance premium, the insurer's obligation to cover the costs, i.e. part of the costs for the provision of health services covered by the contract on voluntary health care, ceases upon the expiration of a period of 30 days from the day when the contractor is handed a written notice on outstanding insurance premiums.

After the expiration of the period referred to in the previous paragraph of this Article, the insurer may terminate the contract on voluntary health insurance without a subsequent notice period and initiate the procedure of collecting due premiums with the corresponding interest

before the competent court.

In case the Policyholder or the Insured made a false claim or withheld a circumstance that was of such nature that the Insurer would not have concluded the Agreement under the same terms and conditions had it known about the actual state of affairs, the Insurer may request the annulment of the Agreement.

CANCELLATION OF THE INSURANCE AGREEMENT
Article 20.

Each contracting party may cancel an insurance contract with an indefinite duration, unless the contract has terminated on some other basis.

Cancellation is made in writing, no later than three months before the end of the current year of insurance.

If the insurance is concluded for a term longer than five years, each party may, after the expiration of the agreed deadline, with a six months notice period, declare in writing to the other party the wish to terminate the contract.

COMPLAINTS OF THE INSURED
Article 21.

An insured person who considers that his rights under the insurance contract have been violated by the decision of the Insurer regarding a claim, can submit a complaint to the Insurer within 30 days from the date of receiving the decision.

The insurer is obliged to make a decision on the complaint within 14 days of it's receipt.

DATA ON THE INSURED
Article 22.

The Insured authorizes the Insurer to collect, verify, process, store, transfer and use personal data necessary to conclude the Insurance Agreement in accordance with the law governing personal data protection.

The Insurer undertakes to keep the data referred to in paragraph 1) of this Article as a trade secret, in accordance with law.

During the conclusion of the contract the insurer will not ask for genetic data, that is, the results of genetic tests for certain hereditary diseases of the person who shows a clear intention to conclude the contract, as well as for his relatives, regardless of the type and level of kinship.

Notices on processing personal data

Joint-stock insurance company "Triglav Osiguranje" Beograd, with its registered office at Novi Beograd, Milutina Milankovića 7a, registration number 07082428, in the capacity of personal data controller and in terms of giving valid consent to the processing of personal data, submits notices in accordance with the law on protection of personal data, as follows:

- Contact details of the person for personal data protection in the Company: dpo@triglav.rs
- The subject of processing are personal data and special types of data contained in the insurance contract and the documentation on the basis of which the contract is concluded.
- The purpose of data collection and further processing is to form an offer, to conclude an insurance contract, as well as to exercise the rights and obligations assumed by concluding an insurance contract.
- Data is used and processed in the following ways: by collecting, recording, sorting, grouping, i.e. structuring, storing, comparing or modifying, discovering, inspecting, using, detecting through transmission, i.e. delivering, duplicating, disseminating or otherwise making available, comparing, by restricting, deleting or destroying. Processing is done automatically or non-automatically. The Company keeps appropriate records on the collected data, a structured set of personal data that is available in accordance with the special criteria, i.e. data collections, in accordance with the law.
- The recipients of the data are the National Bank of Serbia, other state bodies on the basis of their public authorizations, authorized auditing companies, the Association of Insurers of Serbia, co-insurers, reinsurers, insurance intermediaries and agents, assistance companies and health care providers, as well as other persons on the basis of concluded contracts.
- Zavarovalnica Triglav d.d., Ljubljana Miklošićeva cesta 19, Republic of Slovenia, processes personal data by order and on behalf of the Company, in accordance with the law governing the protection of personal data.
- The legal basis for processing is the law and the insurance contract.
- The person whom the personal data refer to has the right to request from the Operator the access, correction, addition or deletion of his personal data, i.e. he has the right to limit the processing in case of disputing the accuracy or illegal processing, the right to object to the person in charge of personal data protection, as well as the right to data portability. In case of unauthorised processing of data, the person whom the personal data refer to has the right to address the Commissioner for Information of Public Importance and Personal Data Protection with a complaint, and has the right to judicial protection.
- The collected data are processed and stored in accordance with the purpose of collection, i.e. in accordance with the legal regulations on the deadlines for storing documentation and data.

THE RIGHT TO RECOURSE
Article 23.

The rights of the Policyholder or the Insured towards a third party are transferred to the Insurer, in the amount of the liability paid out by the Insurer, without the need to obtain any special consent of the Insured person.

In order to exercise the right to recourse as stipulated in paragraph 1) of this Article, the Insured is obliged to provide to the Insurer all the evidence that the Insurer may request, related to the insurance claim.

The costs of obtaining such evidence are borne by the Insurer.

SANCTION CLAUSE - RESTRICTIVE MEASURE TO PREVENT MONEY LAUNDERING AND TERRORISM FINANCING
Article 24.

Joint Stock Insurance Company "Triglav Osiguranje" a.d.o. Beograd, as a restrictive measure to prevent money laundering and terrorist financing, does not provide insurance coverage, and has no obligation to pay claims or any other benefits, regardless of the provisions of the insurance contract, if such payment would expose the insurer to any sanctions, prohibitions and restrictions based on United Nations resolutions, trade or economic sanctions, or violations of the laws and regulations of the European Union, the United Kingdom or the United States.

TRANSITIONAL AND FINAL PROVISIONS
Article25.

These General Terms and Conditions may be amended following the procedure and manner in which they are adopted.

Regarding the existing insurance agreements, the General Terms and Conditions based on which such agreements were concluded shall apply until expiry of the insurance year, unless the terms and conditions are changed as a result of changes in legislation, which is beyond control of the Insurer.

Should the Insurer amend the General Terms and Conditions of Insurance, it is obliged to make a written notification thereof to the Policyholder, i.e. the Insured, with whom it has concluded Insurance Agreement for a perennial term, as well as in other convenient way (daily press, radio, television, the Insurer's web site, etc.) at least 30 days before the end of the current year of insurance.

The contracting party has the right to cancel the insurance contract within 30 days from the day of receiving the notice referred to in paragraph 3 of this Article. In that case, the contract referred to in paragraph 2 of this Article shall terminate at the expiration of the current year of insurance.

If the contracting party does not cancel the insurance contract within the term referred to in paragraph 4 of this Article, the insurance contract shall be renewed in accordance with the changes made in the General terms and conditions of insurance. The contracting party may, until the date of application of the new General Conditions, notify the Insurer on the cancellation of the insurance contract, in which case the insurance contract shall terminate on the day of the application of the new General Conditions. Otherwise, the new General Conditions will apply to the new agreement.

Article 26.

Claims arising from the contract expire under the provisions of the Law on Obligations.

Article 27.

The Contracting Parties shall settle all disputes by mutual agreement, and if they fail to do so, they shall contract the jurisdiction of the competent court in the seat of the Insurer.

Article 28.

The provisions of the Law on Obligations and Regulations governing voluntary health insurance are directly applied to all relations of the contracting parties that are not defined by these conditions.

Article 29.

These General Terms and Conditions shall enter into force on the eighth day after the date of their publication on the notice board of the Insurer, and shall be applied upon the approval of the Ministry of Health. The General conditions us-Dzo / 13-08, dated August 23, 2013, cease to be valid on the day of the application of these general conditions.