

GENERAL TERMS AND CONDITIONS OF MEDICAL INSURANCE CONTRACTS FOR NATURAL PERSONS

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Insurer is ERGO Life Insurance SE (registered in Lithuania) that provides its services in Estonia through the Estonian branch of ERGO Life Insurance SE.

Please read the terms and conditions of insurance carefully to understand your rights and obligations, also which events or services do not fall under the insurance cover.

The general terms and conditions of medical insurance contracts outline the definitions used in insurance contracts, also the rights and obligations of the insurer, policyholder and the insured person upon conclusion and performance of a contract.

The general terms and conditions shall apply to all medical insurance products offered 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 of insurance.

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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 a person who has an insurable interest and who has concluded an insurance contract with the insurer.
- 1.3. **Insurable interest** is the interest of the policyholder to insure his/her life and/or health or that of the insured person against a specific insurable risk.
- 1.4. **Insured person** is a natural person specified in the insurance contract, in whose favour the insurance contract is concluded.
- 1.5. **Beneficiary** is a person agreed upon in the insurance contract, who is entitled to insurance indemnity upon occurrence of an insured event.
- 1.6. **Insurable risk** is an event that is independent from the intention of the insured person and is specified in the insurance contract, the arrival of which in the future is probable.
- 1.7. **Insured event** is an event independent from the intention of the insured person, which is in causal relationship with the insurable risk, upon the arrival of which insurance indemnity shall be paid in accordance with the conditions of the insurance contract.
- 1.8. **Waiting period** is a time interval calculated as of conclusion of the insurance contract, no insurance indemnity shall be paid upon insurance events occurring thereof. The duration of waiting period shall be specified in the insurance contract. No waiting period shall be applied to an occurred accident.
- 1.9. **Accident** is an unexpected and unforeseeable event that takes place against the free will of the insured person, as result of which an external and/or violent force causes damage to health of the insured person.
- 1.10. **Deductible** is the amount agreed upon in the insurance contract, which shall be borne by the policyholder or insured person upon an insured event.
- 1.11. **Insurance application** is a document in the form established

by the insurer, which the policyholder shall submit to the insurer, notifying the latter of significant circumstances necessary for evaluation of probability of materialisation of the insurable risk.

- 1.12. **Insurance offer** is a proposal of the insurer to conclude an insurance contract.
- 1.13. **Insurance contract** is an agreement concluded between the insurer and policyholder. The insurance contract consists of the following parts:
 - insurance application;
 - policy;
 - special terms and conditions of insurance (if agreed upon);
 - terms and conditions of insurance;
 - amendments and supplements to the insurance contract.
- 1.14. **Terms and conditions of insurance** are conditions that the insurer applies to a specific insurance relationship. Terms and conditions of insurance are deemed to include these general terms and conditions, insurance conditions of each product, and special conditions.
- 1.15. **Policy** is a document issued by the insurer, which certifies conclusion of the insurance contract. The confirmation of the representative of the insurer on the policy may be original, digital or replicated.
- 1.16. **Payment notice** is the information sent by the insurer, which notifies the policyholder of the imminent payment deadline.
- 1.17. **Insurance period** is a time period on the basis of which insurance premiums are calculated. The duration of insurance period shall be one year.
- 1.18. **Insurance cover** is the obligation of the insurer, upon occurrence of an insured event, to pay the insured sum or insurance indemnity or to perform the contractual obligation in any other manner agreed upon, to the extent, on the conditions and pursuant to the procedure specified in the insurance contract.
- 1.19. **Sum insured** is the amount of money specified in the insurance contract, within the limits of which the insurer shall pay insurance indemnity upon occurrence of an insured event.
- 1.20. **Medical institution** is a medical practice that provides health services, a public or municipal institution or a company entered in the register of medical institutions, which provides health services in conformity with the requirements of legislation.
- 1.21. **Indemnity application** is a document that is in a form established by the insurer, which the policyholder shall submit to the insurer for receiving insurance indemnity on the basis of the signed insurance contract. The application is available on the insurer's website www.ergo.ee.
- 1.22. **Medical/health services** are the health services that are provided to the insured persons at a licensed medical institution.
- 1.23. **Written notification** is the sending of a notice, application or other information to the insurer, policyholder or any other person agreed upon, in a manner that allows for reproduction of the forwarded information.
- 1.24. **Notification procedure** is a notice, application or other information that shall be sent to the postal address, e-mail address, etc. specified in the insurance contract documents. Information is deemed to be delivered if sent by a notice, application or other communication in the aforementioned manner.

2. Entry into force and validity of insurance contract, payment of insurance premium

- 2.1. An insurance contract shall be concluded on the basis of an insurance application.
- 2.2. An insurance contract is deemed to be concluded if the policyholder has complied with the following conditions:
 - has confirmed the conclusion of the insurance contract with his/her signature;
 - has paid the insurer the first insurance premium;
 - has committed any other act agreed upon in the insurance contract.
- 2.3. An insurance contract shall be concluded for a non-fixed term.

The insurance period shall be one year. The insurer shall issue a new insurance policy for each insurance period unless otherwise agreed upon in the insurance contract.

- 2.4. An insurance contract may be concluded for a fixed term if it is related to training, a stay in a foreign country, travelling, or the performance of a fixed-term work or operation.
- 2.5. If the insured person is not a policyholder, an insurance contract can be concluded only upon the consent of the insured person. If the policyholder insures his/her child who is under his/her custody and has not attained 18 years of age by the time of conclusion of the insurance contract, the insurance application shall be signed by the policyholder on behalf of the child.
- 2.6. The insurance cover shall only apply to health services provided in Estonia. Costs for health services provided outside Estonia shall be compensated only if otherwise specified in the insurance contract. Insurance cover shall be valid 24 hours a day.
- 2.7. The policyholder has the right to designate a third person as a beneficiary and change that person. As regards medical costs, the beneficiary is (a) the insured person if he/she paid the medical costs, or (b) the medical institution that provided the health service agreed upon.
- 2.8. The insurance premium is deemed to be paid at the time when that amount is credited to the bank account of the insurer or is paid to the representative of the insurer in cash or by payment card.
- 2.9. Delay in paying or failure to pay the first insurance premium:
 - 2.9.1. If the policyholder has not paid the insurance premium or the first insurance premium within 14 days after conclusion of the insurance contract, the insurer may withdraw from the contract until the payment is made.
 - 2.9.2. It is assumed that the insurer has withdrawn from the contract if the insurer does not file a claim for collection of the insurance premium within three months as of the time when the premium became collectable.
 - 2.9.3. If the first insurance premium has not been paid by the time when the insured event takes place, the insurer shall be released from its obligation of performance.
- 2.10. If the policyholder has not paid the second or any subsequent insurance premium by the due date, the insurer may send to the policyholder a corresponding notice in writing, giving the policyholder at least a two-week term for making the payment and also notifying of the legal consequences of expiry of the term. If the policyholder pays the insurance premium within one month as of cancellation of the contract or expiry of the due payment date, and an insured event has not taken place before payment, the contract shall not be deemed to be cancelled.
- 2.11. The insurer shall submit a payment notice to notify the policyholder of the imminent due date, bank account of the insurer and the reference number. The payment notice may be sent on paper or electronically.
- 2.12. If the payment notice is not sent or received, it shall not release the policyholder from the obligation to pay the insurance premium.
- 2.13. If the insurance premium is paid incorrectly and, on the basis of the available information, the insurer is not able to determine the particular insurance contract for which the premium is paid, the premium is deemed to be unpaid until the insurance contract is identified for which the premium is paid.
- 2.14. If the policyholder pays an amount that is smaller than prescribed, the insurer shall contact the policyholder. The insurance premium is deemed to be received only when the entire prescribed amount is received.
- 2.15. If the policyholder pays an amount that is larger than prescribed, it shall be refunded on the basis of an application from the policyholder.

3. Change of insurance premium and insurance cover

- 3.1. After conclusion of an insurance contract, the insurer may change the insurance premium or change the insurance coverage, establish or change the deductible in the following cases:
 - 3.1.1. a change of 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 costs 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 insurance events;
 - 3.1.4. a change in the degree of national compensation for sickness insurance service (if the degree of national compensation declines, the obligation of the insurer increases and, as a result thereof, 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 performance obligation of the insurer also changes and, as a result thereof, it is substantiated to increase the insurance premium or change the insurance cover);
 - 3.1.6. amendment of legislation changing the health care administration (for example, if the performance obligation of the insurer increases due to amendments to the legislation).
- 3.2. The insurer has the right to increase the initial premium, starting from a certain age of the insured person, up to an amount that the insurance rate prescribes for an insured person who concludes an insurance contract at a corresponding age. In each next insurance period, the insurance premium will increase by an amount equal to an increase in the premium rate of a person who concluded the insurance contract.
 - 3.3. The insurer shall notify the policyholder of changes to the insurance contract at least one month in advance before entry into force of the changes.

4. Termination of contract and payment of insurance premium balance

- 4.1. The policyholder may cancel the medical insurance contract, by giving at least three months' notice of cancellation, by taking into account that the contract expires upon expiry of the insurance period.
- 4.2. The insurer has the right to cancel the sickness insurance contract concluded for a shorter period than one year, by giving at least three days' notice thereof.
- 4.4. The insurer has the right to contractual termination of the medical insurance contract within the first three years, by giving a three months' notice thereof.
- 4.5. If the insurer increases the premium or excess or reduces its obligations, the policyholder may cancel the contract within one month as of receipt of the notice of change. In such case, the insurance contract shall expire upon entry into force of the increase of insurance premium or the reduction of obligations.
- 4.6. The policyholder may withdraw from the insurance contract within 14 days as of conclusion of 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 shall refund to the policyholder the premium paid by the latter, less administration costs according to the applicable price list.
- 4.7. Upon cancellation of and withdrawal from the contract, the policyholder has the right to refund of the premium paid for the remaining insurance period, less 25% for administration costs. Upon refunding the premium, account shall be taken, inter alia, of the degree to which the insurer already has or is about to have the obligation to pay indemnity.

5. Obligations of policyholder and insured person. Notification obligation of insurer

- 5.1. Obligations of policyholder and/or insured person:
 - 5.1.1. the policyholder is required to pay insurance premiums;
 - 5.1.2. the policyholder and insured persons are required to perform the obligations set out in the insurance contract;
 - 5.1.3. upon conclusion of a contract, the policyholder and insured person shall notify the insurer of all circumstances known to them, which have an impact, due to the nature thereof, on the insurer's decision to conclude a contract or do so on the conditions agreed upon (significant circumstances). Such circumstance is considered significant for which the insurer has directly requested information in a format that can be reproduced in writing. If the policyholder or insured person has not notified the insurer, upon conclusion of the insur-

ance contract, of all significant circumstances known to them, also if they have intentionally avoided awareness of a significant circumstance or have supplied incorrect information with regard thereof, the insurer may either withdraw from the contract or demand a higher premium from the policyholder, pursuant to the legislation. The insurer may exercise such right within three years as of conclusion of the contract;

- 5.1.4. the insured person is required to make all efforts for restoring his/her health and comply with the prescriptions of a medical specialist;
 - 5.1.5. the policyholder and/or insured person is required to immediately notify the insurer of an increase in the likelihood of insurable risk, for example, if the occupation or area of activity of the insured changes, the insured starts to pursue high-risk hobbies and/or activities, or if the insured person enters the active service of the Defence Forces, etc. 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 insurable risk pursuant to the applicable rates, the insurer has the right to change the premium, by giving the policyholder at least one month's notice of the new amount of the insurance premium.
- 5.2. Obligations of policyholder and insured person upon occurrence of an insured event:
- 5.2.1. the policyholder and insured person are required, at the first possibility, to notify the insurer of each insured event in writing and apply all measures to identify the circumstances of the insured event and follow the instructions of the insurer, if the circumstances allow for this;
 - 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 certify occurrence, place, date and time of the insured event (this applies to originals of all certificates, invoices and payment documents);
 - 5.2.3. the insured person is required to turn to a licenced physician or medical institution, follow the physician's instructions and, if hospital treatment is determined for the insured person, the insurer shall be immediately notified thereof;
 - 5.2.4. upon an insured event, the insured person is required to submit to a medical institution or physician a health insurance card issued by the insurer. If for receiving the emergency health care, the insured person turns to a medical institution, with whom the insurer does not have a cooperation agreement, the insurer shall be informed thereof at the first possibility;
 - 5.2.5. upon the request of the insurer, the insured person is required to undergo a medical check as determined by the insurer.

During validity of the insurance contract, the insurer is required to inform the policyholder of any change in the name, legal form, address of the insurer, as well as in the address of the insurance supervision authority or an office where the insurance contract is concluded. The policyholder shall be notified of the aforementioned changes via the insurer's website www.ergo.ee or media.

6. Decision on payment of insurance indemnity or refusal to make the payment, takeover of the right of claim

- 6.1. The insurer shall make a decision on payment of the insurance indemnity or refusal to make the payment within 15 working days as of the receipt of all necessary documents.
- 6.2. The insured person's right of claim against a person liable for damage shall transfer to the insurer to the extent of paid insurance indemnity (right of recourse).
- 6.3. If the right of recourse in favour of the insurer is not partially or fully created due to the activities or omissions of the insured person or policyholder, the insurer has the right to reduce the indemnity accordingly or demand refund of the paid indemnity to the extent of that which cannot be recovered.
- 6.4. The insurer has the right to withhold from the indemnity the amount of excess set out 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 insurance indemnity, the sum insured shall decline 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 communication channels of the insured person, including e-mail. If the insured person wants to receive also the decision, apart from the aforementioned information, he/she shall notify the insurer thereof and shall give the address to which the decision should be sent. A notice of payment of insurance indemnity may also be sent via other communication channels specified in the application of the insured person.
- 6.7. Within 15 working days as of receiving the indemnity application, the insurer is required to notify the insured person in writing as to which additional documents are necessary in order to adopt a decision on payment of indemnity.
- 6.8. If the documents submitted for receiving indemnity are incomplete, are incorrectly filled out and/or additional time is necessary for verifying the insured event or submitted documents, the insurer has the right to postpone the adoption of a decision for up to one month.
- 6.9. The insured person shall submit to the insurer an indemnity application, original invoice for health services and, upon request of the insurer, also a document certifying the payment of the invoice.
- 6.10. It is also required to submit to the insurer an extract of a medical institution or physician from the health file or health card. The extract, with the data concerning the insured event, shall be issued by the medical institution or physician who provided medical assistance.
- 6.11. Insurance indemnity shall be paid directly to the insured or the medical institution
- 6.12. If the insured person turns to a medical institution or physician who is not a cooperation partner of the insurer, he/she shall be compensated for the used service on the basis of the average market price unless otherwise specified in the insurance contract.
- 6.13. Within 14 days as of the end of the insurance period, the insurer shall also compensate for expenses incurred after the end of the insurance period if the insured event lasts longer than the term of the insurance contract.
- 6.14. The indemnity shall be paid to a medical institution or physician on the basis of the treatment bills submitted by them, in accordance with the conditions of the agreement concluded between the insurer and medical institution or the physician.
- 6.15. If continuance of treatment is medically not substantiated, the insurer may reduce indemnity accordingly or refuse to pay indemnity.

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

- 7.1. The insured event shall not include the following events or any damage created as a result thereof:
 - 7.1.1. damage that is directly or indirectly caused by a terrorist act or its preparation. A terrorist act is understood as such organised violence or a threat to use violence for political, religious, ideological or ethnic purposes, which is committed by one person or a group of persons, who act in the name of organisation(s) or government(s) or according to their instructions or in cooperation with them, in order to influence the government and/or threaten society or any part thereof;
 - 7.1.2. damage that is created in connection with such events as a strike, uprising, civil unrest, acts of civil disobedience, riot, armed clashes, civil disturbances, revolution, military coup d'etat, usurpation of military power, war, civil war, state of war, military activities, invasion, acts of foreign enemies, acts of state and local authorities, amendments to laws and other legislative acts, orders of the government, acts of God, pandemics, other natural disasters, epidemics (large-scale spread of infectious diseases, of which a state authority has notified);
 - 7.1.3. damage caused by direct or indirect effect of nuclear energy or radioactive radiation, electromagnetic, light or thermal radiation, as a result of radiation poisoning or radioactive contamination;
 - 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 during a stay at a custodial institution;
- 7.1.5. a disease or accident, which is intentionally caused by the policyholder or insured person;
 - 7.1.6. an incident that did not occur during validity of the insurance contract or on the covered territory agreed upon;
 - 7.1.7. a situation where an accident is caused by mental, psychological or consciousness disorders;
 - 7.1.8. a disease or accident that is caused by the insured person as a result of using alcoholic, narcotic or other intoxicating substances, or due to diagnostics or treatment of a health disorder resulting from the use of alcoholic, narcotic or other intoxicating substances, psychological diseases or their syndromes diagnostics, also as a result of treatment of alcoholism, drug addiction, substance dependence, sexually transmitted diseases, etc.;
 - 7.1.9. damage resulting from such treatment, which was not necessary for direct treatment of the disease, such as cosmetic procedures, plastic surgery, cosmetic services and/or aesthetic enhancement, cosmetic surgery;
 - 7.1.10. damage caused to continuously used medical devices, such as spectacles, lenses, prosthetic appliances, hearing aid, invalid carriages, crutches;
 - 7.1.11. non-traditional diagnostics and/or treatment or self-treatment, participation in closed clinical trials on medical products, treatment provided to a spouse, parents and children of the insured person;
 - 7.1.12. such part of damage that exceeds the average price level of public medical services, or the expenses from the payment of which the insured person is released by applicable legislative acts;
 - 7.1.13. use of services provided without medical indication or if the insured person refused medical assistance or surgery, and therefore further damage was caused to his/her life or health;
 - 7.1.14. damage caused in connection with participation of the insured person in the international operations of Estonian Defence Forces, enrolment or participation in the active service, including service in the National Defence League, participation in military operations and training;
 - 7.1.15. a situation where the insured person drives a vehicle without the right to drive a vehicle of the corresponding category and/or substantially violates the requirements set out in the applicable Traffic Act;
 - 7.1.16. expenses incurred due to traumas or bodily injuries, received as a result of engagement in high-risk sports or hobbies, also competitive sports and relevant training. High-risk sports or hobbies include motor sport, bungee jumps, boxing, mountaineering, downhill racing and other extreme sports, any professional sports and other sports and hobbies involving similar risks;
 - 7.1.17. mainly sexually transmitted diseases (syphilis, gonococcal infections, venereal chlamydia granuloma and other chlamydia diseases, chancroid, klebsiella granulomatis, donovanosis, trichomoniasis, anogenital herpes virus-infections), treatment of AIDS and HIV, their diagnostics and treatment determined by a sex pathologist;
 - 7.1.18. service expenses not previously agreed upon between the insured person and insurer if the insurance contract sets out an obligation to obtain prior approval of the insurer for the expenses;
 - 7.1.19. treatment costs for a disease or trauma diagnosed before entry into force of the insurance contract, for a chronic or congenital disease;
 - 7.1.20. damage and treatment costs that are compensated as payment of compulsory insurance (e.g., traffic insurance);
 - 7.1.21. treatment that was not provided by a registered medical institution, physician or nurse; medical assistance (other than emergency care) provided by a physician or nurse who is a close relative (children, parents, siblings, spouse);
 - 7.1.22. psychological or mental diseases and their syndromes diagnostics and treatment;
 - 7.1.23. expenses related to family planning, contraceptives, infertility treatment, assisted reproductive techniques, premature termination of pregnancy without medical indication;
 - 7.1.24. transplantation of organs and tissues, haemodialysis upon chronic renal insufficiency;
 - 7.1.25. costs for cosmetic procedures and treatment, food supplements, dietary cocktails and special food, photodynamic laser treatment and informative lectures;
 - 7.1.26. stay at a sanatorium and treatment provided there, accommodation at a sanatorium for the purpose of nursing;
 - 7.1.27. ambulance call-out and transportation of the sick person by ambulance to a hospital;
 - 7.1.28. suicide attempt and expenses related to suicide.
- 7.2. The insurer shall be partially or fully released from the obligation to perform the insurance contract if:
 - 7.2.1. the policyholder, insured person or beneficiary has violated the obligations set out in 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), violated 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 conclusion of an insurance contract or damage handling;
 - 7.2.4. the insured event has taken place due to gross negligence or intention of the policyholder or insured person. Gross negligence is understood as a situation where the person foresaw or should have foreseen the consequences of his/her behaviour, but recklessly expects that no consequences will arrive due to his/her behaviour or any other circumstances.

8. Processing of personal data and protection of data submitted to the insurer, including confidentiality

- 8.1. The insurer has the right to process the personal data of the policyholder and insured person, without their consent (except for sensitive personal data), for performing the insurance contract concluded in favour of the policyholder or for securing the performance of the contract, assessing the insurable risk or for other procedures preceding conclusion of the contract and issuance of the policy in case if the policyholder has submitted an application for conclusion of the insurance contract and conclusion of the contract requires performance of those procedure(s).
- 8.2. The insured person agrees that, in the case and for the purpose specified in clause 7.1, the insurer shall process also the sensitive personal data of a client (information concerning the health condition or disability of the client).
- 8.3. The insurer has the right to preserve the personal data for securing performance of the contract until the term of expiry of a claim arising from the contract, unless otherwise stipulated in the legislation.
- 8.4. Upon an insured event, a third party may, without the consent of the insured person, forward the personal data to the insurer or enable access to the personal data which are necessary for the insurer to determine the obligation to perform the insurance contract or the extent of such performance. The above also applies to the information concerning the health condition or disability of the insured person, if it is necessary to the insurer for performing the contract, securing the performance of the contract or for determining the obligation of performance and its extent. The insurer shall strictly adhere to the requirements of the Act on Processing of Personal Data.
- 8.5. The policyholder and insured person agree that the insurer may use their personal data (name and contact information) to offer them additional insurance services and forward them information on the services of the insurer.
- 8.6. The policyholder agrees that the insurer may forward his/her personal data to financial companies belonging to the same consolidation group with the insurer, in order to supply to the policyholder the information and additional financial services based on his/her expected financial needs. Such financial companies are ERGO Insurance SE (A. H. Tammsaare tee 47, 11316 Tallinn, tel. 610 6500, info@ergo.ee) and ERGO Funds AS (A. H. Tammsaare tee 47, 11316 Tallinn, tel. 610 6500, info@ergo.ee), D.A.S. Õigusabikuluude Kindlustuse AS, Veerenni 58a, 11314 Tallinn, tel 679 9450, info@das.ee). The personal data to be forwarded include the name and contact data

of the person (address, phone number, e-mail address). The policyholder may withdraw at any time his/her consent to data processing. The withdrawal of the consent does not have any retrospective effect. The policyholder has the right to prohibit the processing of data concerning him/her for examination of consumer habits or for direct marketing.

9. Procedure for settlement of disputes

9.1. 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 shall be submitted to the insurer and the insurer must be provided with an opportunity to reply to the claim. If the client is not satisfied with the reply from the insurer, the client may turn to an insurance conciliation body (additional information is available on the Estonian Insurance Association's website www.eksl.ee).

9.2. Any disputes arising from insurance contracts (including disputes concerning which no agreement can be reached at an insurance conciliation body) shall be settled at Harju County Court. The policyholder may submit a complaint concerning the activities of the insurer to the Financial Supervision Authority.

10. Use of foreign language documents

10.1. A translation into a foreign language may be attached to the Estonian-language documents of the insurance contract. The translation has only an explanatory meaning. Upon any inconsistencies between the translation and Estonian-language document, the Estonian-language document shall prevail.

10.2. If a foreign-language document (international clauses, etc.) is a part of the insurance contract as agreed upon, the Estonian-language translation of that document shall be appended to the insurance contract.