LIMITED LIABILITY COMPANY
"RUSSIAN INSURANCE COMPANY "EUROINS"

«Approved»:
General Director

/signature/ O.B. Makova
Stamp here /Stamp: SMOLENSK, LIMITED LIABILITY COMPANY "RUSSIAN INSURANCE COMPANY "EUROINS"/

(Order No. 05-1006/2022 dated 10.06.2022)

CONDITIONS OF THE CONTRACT OF VOLUNTARY COMBINED INSURANCE OF TRAVELERS

SECTION I. GENERAL PROVISIONS

1. GENERAL PROVISIONS. TERMS AND DEFINITIONS

1.1. In accordance with these Conditions of the contract of voluntary combined insurance of travelers (hereinafter – Insurance Conditions, Conditions), developed on the basis of the Rules of voluntary combined insurance of travelers dated ___________ (further – Insurance Rules, Rules), LLC RIC "EUROINS", hereinafter referred to as the Insurer, provides insurance for citizens traveling outside the country or place of permanent residence by concluding appropriate Insurance Contracts with legal or capable individuals.

In everything that is not regulated by these Conditions, the terms and conditions of the Insurance Rules apply. If there are contradictions between these Conditions and the Insurance Rules, the provisions of these Conditions shall prevail.

Under the Contract of voluntary combined insurance of travelers (hereinafter –Insurance Contract, Contract) the Insurer undertakes to compensate losses (pay insurance indemnity) for the payment (insurance premium) stipulated by the Insurance Contract upon the occurrence of an event (insured event) stipulated in the Insurance Contract within the limits of the sum insured determined by the Insurance Contract and in accordance with these Insurance Conditions.

1.2. The Insurance Contract is concluded in writing and is drawn up on the form of an insurance Policy of the established sample (hereinafter referred to as the Insurance Policy, Policy) signed by the Insurer, with the appendix of these Insurance Conditions, which are an integral part of the Insurance Contract.

1.3. Terms and definitions used in these Insurance Conditions:

Policyholder(s) - capable individuals and legal entities of any organizational and legal forms, individual entrepreneurs who have concluded an Insurance Contract with the Insurer.

If the Policyholder, who is individual, has concluded an Insurance Contract for his/her property interests, then he/she is an Insured Person.

Policyholders, who are legal entities or individual entrepreneurs, conclude Insurance Contracts with the Insurer for third parties in favor of the latter – Insured persons.

Insured person - an individual named in the Insurance Contract, whose property interests are insured under the Contract.

According to the "Cancellation of the trip" risk, only a citizen of the Russian Federation can be an insured person.

Beneficiary – a natural or legal person named by the Policyholder in the insurance contract with the written consent of the Insured Person as the recipient of the insurance benefit for one or more insurance risks, in case of which this Insured Person is insured.

Service company (assistance) is an organization that, on behalf of the Insurer, provides round the clock organization of services provided for in these Insurance Conditions.

Close relatives – officially registered spouse, father, mother, children, including adopted children, adoptive parents, siblings, grandparents, grandchildren, official guardians and people under guardianship.

Insurance territory – the territory specified in the Insurance Contract, which is covered by the Insurance Contract. An event that occurred outside the insurance territory specified in the Insurance Contract is not insured and does not entail the obligation of the Insurer to make an insurance payment.

Place of permanent residence:

- **for citizens of the Russian Federation** - the territory within the administrative border of the locality where the Insured Person is registered (temporarily or permanently). If the Insured Person has temporary and permanent registration, the place of permanent residence is considered to be the territory within the administrative border of the locality where the Insured Person is permanently registered. As well as the country of second citizenship and/or the country in which a permanent or temporary residence permit is issued.

- **for foreign citizens and stateless persons** - the country of which the Insured is a citizen and/or in which the Insured has a temporary residence permit or a residence permit in this country. Obtaining a residence permit in a country that is part of the insurance territory for education purposes does not affect the status of the place of permanent residence indicated at the conclusion of the Insurance Contract.

Dangerous diseases — diseases with codes A36, A22, A15, A00, A20, B34.2, U07.1, U07.2 (U04.9, U10.9, U10, including the consequences of these diseases) in accordance with the classification according to ICD 10*, posing a danger to others and requiring quarantine measures included in the list of such diseases by Decree of the Government of the Russian Federation No. 715 dated 01.12.2004 (as amended at the time of the insured event) "On approval of the list of socially significant diseases and the list of diseases that pose a danger to others".

* ICD 10 — International Statistical Classification of Diseases and Health-related Problems (10th revision).

Trip (insured trip) – departure and stay of the Insured person outside the country or place of permanent residence for tourist, business, private or other purposes (including for the purpose of education, employment), not excluded by these Rules and/or the Insurance Contract for the term of which the Insurance Contract is concluded and within the Territory insurance specified in the Insurance Contract.

The movement of the Insured Person for the purpose of changing permanent residence is not a Trip.

Baggage - personal belongings of the Insured person carried by him/her during the trip and officially handed over to the baggage of the transport organization (carrier) carrying out the transportation of the Insured. The weight and the fact of baggage delivery to the carrier are confirmed by the baggage receipt.

Sudden illness - an acute illness or exacerbation of a chronic illness that unexpectedly occurred during the Insured Person's trip, requiring emergency and urgent medical intervention.

Within the framework of these Conditions, sudden illnesses do not include an illness for which the Insured Person receives planned therapy, is registered or has been treated by appropriate medical specialists, and preceding the start of the trip, as well as long-term (congenital or acquired), progressive persistent pathological changes in organs and/or systems that require medical or surgical treatment for their elimination or reduction of negative effects on the body.

Chronic disease is a disease that has at least two of the following characteristics:

- may exist for an indefinite period of time;

- there is a possibility of recurrence;

- has a permanent nature;

- requires long-term monitoring, consultations, examinations, studies or tests.

Accident is a sudden physical impact of various external factors (mechanical, thermal, chemical, etc.) on the body of the Insured Person that occurred during the validity period of the Insurance Contract, regardless of the will of the Insured Person, and resulted in bodily injuries, violations of the physiological functions of the body of the Insured

person or his/her death.

Accidents include attacks by people or animals (including insects, reptiles), injuries, suffocation, poisoning, frostbite, drowning, electric shock, lightning strike, explosions, accidental ingestion of a foreign body into the respiratory tract.

Accidents do not include any forms of acute, chronic and hereditary diseases, as well as their complications (both previously diagnosed and newly identified), including those provoked by external factors, sunburn.

Poisoning is an acute disorder of the vital activity of the body caused by poisonous plants, chemicals (industrial or household), substandard food products, with the exception of intestinal infection (salmonellosis, dysentery, etc.), medicines.

Carrier is any registered carrier engaged in the transportation of passengers by land, water or air, licensed for this type of transportation and performing them on a specific route.

Injury is a violation of the anatomical integrity and physiological function of organs and tissues (fracture and dislocation of bones, bruises, rupture and injury of organs, concussions) resulting from: the fall of an object on the Insured person, the fall of the Insured person himself/herself, during the movement of vehicles or their accident, when using machines, mechanisms, tools of production and all kinds of tools.

Disability is a social insufficiency due to a violation of health with a persistent disorder of body functions, leading to a restriction of vital activity and the need for social protection.

Urgent medical care is medical care provided in case of sudden acute illnesses, conditions, exacerbations of chronic diseases without obvious signs of a threat to the life of the Insured person.

Emergency medical care is medical care provided in case of sudden acute illnesses, conditions, exacerbations of chronic diseases that pose a threat to the life of the Insured Person.

Emergency dental care - urgent medical measures caused by acute disease of natural teeth and/or surrounding tooth tissues or injuries of natural teeth resulting from an accident.

Medical institution is an organization that has the right (license) to provide medical services under the legislation of the country in which the Insured Person is during the trip.

Medical expenses – expenses for the provision of emergency and urgent medical care as prescribed by a doctor in the event of a sudden illness, exacerbation of a chronic illness, injury and/or poisoning of the Insured Person.

Active rest is a way for the Insured Person to spend time during the trip, including, but not limited to: water entertainment using towed inflatables and parachutes, jet skiing and water skiing; water entertainment in the water park; roller skating, mopeds, motorcycles, scooters and ATVs both as a driver and as a passenger; tours on water transport (except for those who have a special permit to transport passengers); tours on safari, on riding and other animals; beach volleyball, football on the beach, snorkeling, kiting, kayaking, trekking no higher than 1,500 m, horseback riding, playing tennis, golf, touring (riding) on a bicycle, scooter, segway, self-balance scooter; use of sports equipment, tools, devices and means of transportation.

If the Insurance Contract provides for the insurance of the "Active rest" risk, then the "Winter active rest" and "Extreme rest" risks are not insured.

Winter active rest is a way for the Insured Person to spend time during the trip, including, but not limited to: ice skating, downhill and cross-country skiing, except for off-piste skiing; skiboarding, snowboarding, except for off-piste skiing; snowmobiling, sledding; use of sports equipment, tools, devices and means of transportation.

If the Insurance Contract provides for the insurance of the "Winter active rest" risk, then the "Active rest" and "Extreme rest" risks are not insured.

Extreme rest is a way for the Insured Person to spend time during the trip, including, but not limited to: mountaineering, rock climbing, ice climbing, trekking above 1,500 m, rafting, surfing, windsurfing, freestyle, skateboarding, sky surfing, hang gliding, hunting; skydiving; descent into caves, including guided tours; water tourism on yachts, kayaking and rafts on rapid rivers; jumping from a springboard, including from a water one; participation in horse racing and car racing, any form of flights, with the exception of those performed as a passenger who has paid for a regular flight or a licensed charter flight on a certain route.

If the Insurance Contract provides for the insurance of the "Extreme rest" risk, then the "Winter active rest" and "Active rest" risks are not insured.

Professional and amateur sports - the process of participation of the Insured person in sports competitions, tournaments, trainings, training camps for a certain sport at the professional or amateur level. Type of sport is indicated in the insurance Policy in the section “Additional risks".

In accordance with these Conditions, professional or amateur sports do not belong to the category of "Active rest", "Winter active rest" or "Extreme rest".

The following types of professional and amateur sports: bobsleigh, downhill skiing, Nordic combination, competitive skiing, sledding, snowboarding, biathlon, triathlon, figure skating, hockey - are defined in accordance with these Conditions as "Winter sports".

The following types of professional and amateur sports: aquabike, rafting, surfing, windsurfing, freestyle, skateboarding, sky surfing, hang gliding, diving with a dive up to 40m, mountaineering, rock climbing, ski jumping - are defined in accordance with these Conditions as "Extreme sports".

The list of sports disciplines included in sports is determined by the All-Russian Register of Sports in the edition valid on the date of conclusion of the insurance contract.

Professional activity is a trip for the purpose of employment by an Insured person in the insurance territory (when it is required to open a work visa, obtain a work permit, etc.).

The term "Professional activity" does not include trips for the purpose of carrying out work related to work in office premises, as well as participation of the Insured Person in conferences, symposiums, seminars, skills workshops, lectures, exhibitions, forums, conventions, congresses, plenums, assemblies, etc.

Children's sports camp are organizations of seasonal or year-round activity, regardless of organizational and legal forms and forms of ownership, whose main activity is aimed at sports development and health improvement of children.

Within the framework of these Conditions, the definition of "Children's sports camp" includes both specialized (profile) sports camps in which children purposefully engage in one or more type of sports, and children's health camps, whose activities are aimed at the general physical development and health improvement of children, including children's camps of sanatorium-resort type.

Deductible is a part of losses that are not reimbursed by the Insurer. The deductible can be conditional and unconditional.

With a conditional deductible, the Insurer is released from obligations for the loss if its amount does not exceed the deductible.

With an unconditional deductible, the Insurer's obligations are determined by the amount of the loss minus the deductible.

The deductible is determined as a percentage of the insured amount or in absolute value.

A temporary deductible is a period of time from the beginning of the term of the Insurance Contract, during which the Insurer's liability does not apply to events that have occurred with the Insured person that have signs of insurance in accordance with the conditions of the Insurance Contract. Any expenses and losses incurred by the Policyholder (Insured Person) during the period of the temporary deductible are not reimbursed by the Insurer.

2. OBJECT OF INSURANCE, INSURANCE RISKS

2.1. The object of insurance is the property interests of the Insured Person traveling outside the country or place of permanent residence that do not contradict the legislation of the Russian Federation, which arose during the term of the Insurance Contract in the territory specified in the Insurance Contract and are associated with the occurrence of the following events (insurance risks):

- unforeseen expenses due to the need to receive emergency and urgent medical and other assistance, including medical and transport assistance, upon the occurrence of an insured event in the amount stipulated by the Insurance Contract - **the "Medical and other emergency expenses" risk;**

- losses incurred as a result of the Insured Person's inability to make a trip for reasons stipulated in the Insurance Contract - **the "Cancellation of the trip" risk**;

- causing harm to the life and health of the Insured person as a result of an accident - **the "Accident" risk;**

- occurrence of civil liability of the Insured person, entailing the obligation to compensate for damage caused to the life, health and/or property of third parties - **the "Civil liability" risk**;

- losses incurred as a result of loss or missing of baggage belonging to the Insured person, handed over to the baggage compartment of the transport organization (carrier) carrying out the transportation of the Insured person - **the "Loss of baggage" risk.**

2.2. The Insurance Contract may be concluded both with respect to all of the above risks, and with respect to individual risks (any combination thereof) from among those listed in clause 2.1. of these Conditions - at the choice of the Policyholder.

The specific list of events, in case of occurrence of which insurance (insurance cases) is carried out, is determined in the insurance contract at its conclusion.

3. GENERAL EXCLUSIONS FROM INSURANCE COVERAGE. GROUNDS FOR REFUSAL OF INSURANCE PAYMENT

3.1. Under the Insurance Contract, insured events do not include any losses and expenses caused by the following events:

3.1.1. Exposure to nuclear explosion, radiation or radioactive contamination;

3.1.2. Military actions, as well as maneuvers or other military activities;

3.1.3. Civil war, popular unrest of any kind or strikes;

3.1.4. Terrorist acts;

3.1.5. Natural disasters and their consequences, other circumstances of force majeure;

3.1.6. Service of the Insured Person in the armed forces and paramilitary formations of any country, participation of the Insured Person in combat, military and any other actions related to the use of weapons;

3.1.7. Actions and decisions of state authorities and/or local self-government bodies that prevent the Insurer from fulfilling its obligations;

3.1.8. Environmental pollution, epidemics.

3.2. Any events that occurred with the Insured Person during the validity period of the Insurance Contract in the Insurance territory are not recognized as insured events:

3.2.1. when the Insured Person is intoxicated;

3.2.2. if the Insured Person is in a state of narcotic or toxic intoxication (poisoning), including due to the use of narcotic, potent and psychotropic substances or medications without a doctor's prescription (or according to a doctor's prescription, but in violation of the dosage indicated);

3.2.3. as a result of suicide, attempted suicide, intentional self-harm, or if the Insured has exposed himself/herself to unjustified risk;

3.2.4. when the Insured Person commits or attempts to commit illegal actions;

3.2.5. as a result of intentional actions of the Insured Person, as well as persons acting on his/her behalf, aimed at the occurrence of an insured event;

3.2.6. as a result of the commission (attempt to commit) by the Insured person of a criminal offense that is in direct causal connection with an event that has the characteristics of an insured event;

3.2.7. when the Insured Person is driving a vehicle in the absence of proper driving rights, or being in a state of alcoholic, toxic or narcotic intoxication of any severity, or under the influence of medications contraindicated when driving vehicles, as well as when the Insured person transfers control of the vehicle to a person who does not have the necessary driving rights or to a person who is in a state of alcoholic, toxic or narcotic intoxication of any severity or under the influence of medications, contraindicated when driving vehicles.

3.3. The Insurance does not cover and the Insurer does not reimburse the expenses incurred by the Insured Person in connection with the following:

3.3.1. professional and amateur sports, including participation of the Insured person in sports competitions, tournaments and training camps, if the name of a specific sport is not specified in the Insurance Policy in the "Additional risks" section;

3.3.2. active rest, if the Insurance Policy does not specify "Active rest" in the "Additional risks" section;

3.3.3. winter active rest, if the Insurance Policy does not specify "Winter active rest" in the "Additional risks" section;

3.3.4. extreme rest, if the Insurance Policy does not specify "Extreme rest" in the "Additional risks" section;

3.3.5. the Insured Person's performance of official, labor or other activities (including employment) involving physical activity and capable of increasing the risk of an insured event, unless the name of a specific profession is indicated in the Insurance Policy in the "Additional Risks" section.

3.3.6. during the stay of the Insured person in a children's sports or health camp, if the Insurance Policy does not specify "Children's sports camp" in the section "Additional risks".

3.4. In any case, the Insurer does not cover the following costs:

3.4.1. related to reimbursement of:

3.4.1.1. moral damage;

3.4.1.2. lost profits;

3.4.1.3. social compensation;

3.4.1.4. compensation (guarantee payments) in order to reimburse the costs associated with the performance of the Insured Person's labor and/or professional duties (labor compensation);

3.4.1.5. compensation of wages in case of temporary disability of the Insured person;

3.4.1.6. any other compensation, payments, allowances, penalties, punitive sanctions, interest, commission fees, including in the implementation of financial transactions charged by banks, payment systems, collection agencies and other organizations engaged in financial transactions.

3.4.2. exceeding the insurance amounts and compensation limits established by this insurance contract, as reflected in Sections II and V of this insurance contract.

3.5 The Insurer has the right to refuse insurance payment if:

3.5.1. The Policyholder (the Insured Person) has informed the Insurer knowingly false information about the object of insurance;

3.5.2. in other cases provided for by legislative acts of the Russian Federation.

In cases stipulated by law, the Insurer may be exempted from payment of insurance indemnity upon the occurrence of an insured event due to gross negligence of the Policyholder (Insured Person).

3.6. Reimbursement to the Insured person of expenses caused by an insured event stipulated in the Insurance Contract, by the person responsible for their occurrence, or by another Insurer (in the case of double insurance), releases the Insurer from the obligation to pay insurance compensation.

3.7. Expenses (losses) caused by events stipulated in the Insurance Contract that occurred even during the validity period of the Insurance Contract, but caused by reasons that occurred before the insurance began, are not subject to compensation.

3.8. The decision of the Insurer to refuse insurance payment is sent to the Policyholder (Insured person, Beneficiary) in writing with a reasoned justification of the reasons for the refusal (with references to the rules of law and/or the conditions of the Insurance Contract and/or the Conditions and/or Rules of Insurance within 3 working days from the date of such decision.

4. INSURANCE AMOUNT, INSURANCE PREMIUM, INSURANCE PAYMENT

4.1. The amount insured is the amount of money determined by the Insurance Contract, within which the Insurer is responsible for fulfilling its obligations under the Insurance Contract and, based on which, the size of the insurance premium and insurance payment are established upon the occurrence of an insured event.

4.2. The insurance amount is set for the entire term of the Insurance Contract.

4.2.1. The insurance amount for citizens of the Russian Federation traveling abroad and foreign citizens traveling outside the country of citizenship is set in foreign currency.

4.2.2. The insurance amount for citizens of the Russian Federation traveling on the territory of the Russian Federation is set in rubles, for foreign citizens entering the territory of the Russian Federation – in foreign currency.

4.3. The insurance amount is established by agreement of the parties separately for each insurance risk provided for in the Insurance Contract and is indicated in the Insurance Policy.

4.4. The insurance amount for each risk is aggregate, that is, after each insurance payment, the remaining insurance amount is reduced by the amount of the payment made.

4.5. The Insurer has the right to set the maximum amount of payment (hereinafter referred to as the compensation limit) for specific types of services, expenses, diseases. If the amount of payment for a specific type of services, expenses, or illness exceeds the compensation limit established by the Insurance Contract, then the amount of

expenses exceeding the compensation limit is paid by the Policyholder/Insured person independently. The compensation limit is set in conventional units (units), which are determined by the currency of the Insurance Contract.

4.6. Within the framework of these Conditions, a conventional unit is understood to be a foreign currency in which the insured amount is indicated in the Insurance Policy.

4.7. The insurance amount for the **"Medical and other emergency expenses"** risk is established for each insured person in the amount determined based on the requirements for the amount of the insured amount imposed by a foreign state, but not less than the amount established by the current legislation of the Russian Federation on the date of conclusion of the Insurance Contract.

4.8. The insurance amount for the "**Cancellation of the trip**" risk is established for all Insured persons specified in the Insurance Contract (Insurance Policy), and may not exceed the actual expenses of the Policyholder (Insured person) for the purchase of tourist services in accordance with the contract on the sale of a tourist product. The insurance amount for a self-organized trip cannot exceed the cost of paid hotel accommodation and/or the cost of paid travel.

4.9. The sum insured for the risks of "**Accident**", "**Civil liability**" is established for each Insured person.

4.10. The insured amount for the "**Loss of baggage**" risk is established by agreement of the Policyholder and the Insurer within the actual (insured) value of the baggage.

4.11. If in the Insurance Contract (Insurance Policy) the insured amount is set in a foreign currency, then in order to determine the amount of the insurance benefit, the amount of expenses is recalculated in rubles at the loss currency exchange rate established by the Central Bank of the Russian Federation on the date of the insured event. At the same time, the total amount of insurance payments for each risk for each Insured Person may not exceed the ruble equivalent of the insured amount fixed in the contract (policy) insurance for each insured risk. The calculation of the equivalent of the insured amount in rubles is carried out at the official exchange rate of the Central Bank of the Russian Federation on the date of the incident (insured event), but not higher than the rate of the Central Bank of the Russian Federation on the date of conclusion of the Insurance Contract (Policy).

4.12. Within the framework of these conditions, the following deductibles are provided:

4.12.1. for the "**Medical and other emergency expenses**" risk in the case of registration and payment of the Insurance Contract by the Policyholder at the time of the Insured Person's stay in the insurance territory, an unconditional deductible is established for each Insured – 50 (fifty) units for each insured event.

4.12.2. according to the "**Medical and other emergency expenses**" risk, a deductible is established for each Insured – 50 (fifty) units for each case of outpatient care, if the Insurance Contract specifies the insurance program A, more than 90 days are indicated in the column "Number of insured days" and any insurance territory is indicated, with the exception of the territory of the Schengen countries (hereinafter referred to as the Schengen countries) and Bulgaria.

4.13. The insurance premium is understood as the insurance fee that the Policyholder is obliged to pay to the Insurer in accordance with clause 4.15. of these Conditions.

One-time payment of the premium in full before the start of the term of the Insurance Contract is a prerequisite for the conclusion of the Insurance Contract. If the insurance premium is not paid within the specified time and in full, the Insurance Contract is considered not concluded and no payments are made under it.

4.14. The amount of the insurance premium for each risk is determined depending on the insurance program chosen by the Policyholder, the insured amount, the insurance territory, the duration of stay in the insurance territory, active rest and/or sports, the availability of a deductible, compensation limits for specific types of services and/or diseases, as well as the age and type of activity of the Insured person and other circumstances affecting the degree of risk, in accordance with the tariff rates.

The tariff rate is a percentage of the insured amount and is determined by the Insurer on the basis of Appendix 1 to the Insurance Rules. In this case, the Insurer has the right to apply correction coefficients.

4.15. The Insurance premium under the Insurance Contract is paid by the Policyholder at a time when the Insurance Contract is concluded in cash or by bank transfer. The day of payment of the insurance premium is considered:

- in case of non-cash payment - the day of receipt of funds to the account of the Insurer or its representative;

- in case of cash payment - the day of payment of the premium in cash to the cashier of the Insurer or their representative.

When determining the amount of the insurance premium in foreign currency in the Insurance Contract, payments under the Insurance Contract are made in rubles, in the amount calculated based on the exchange rate of the corresponding currency established by the Central Bank of the Russian Federation on the date of conclusion of the Insurance Contract.

4.16. Insurance payment is a sum of money paid by the Insurer upon the occurrence of an insured event in the amount and on the conditions established by these Insurance Conditions.

4.17. Insurance payments may not exceed the insurance amounts specified in the Insurance Contract/Insurance Policy for each risk and compensation limits.

4.18. The insurance payment under the Insurance Contract is made in the currency of the Russian Federation, except for the cases provided for by the Federal Law "On the Organization of Insurance Business in the Russian Federation" and the legislation of the Russian Federation on currency regulation and currency control.

For citizens of the Russian Federation - reimbursement of expenses denominated in a currency other than the Russian ruble is made in Russian rubles at the exchange rate of the Central Bank of the Russian Federation for this currency on the date of the insured event, subject to the conditions of clause 4.1. of these Conditions.

For foreign citizens - reimbursement of expenses is made in US dollars, euros or rubles.

4.19. The decision to recognize the event as an insured event and to pay the insurance indemnity is made by the Insurer within 20 (twenty) working days from the date of receipt of all necessary documents provided for in these Insurance Conditions, confirming the fact and circumstances of the occurrence of the insured event and the amount of expenses incurred.

4.19.1. The decision-making period is calculated from the day following the day of receipt by the Insurer of the application for insurance payment and all the Insurance Conditions provided for (the last of the necessary and duly executed documents provided for by the Insurance Conditions) necessary for making a decision on the insurance payment.

4.19.2. The insurer accepts documents for insurance payment according to the inventory of documents indicating the date of receipt of documents. The inventory is signed by the Insurer and the Policyholder (Insured Person), a copy is issued to the Policyholder (Insured Person).

4.20. In the presence of circumstances requiring special investigation, examinations and inspections, as well as obtaining additional information from medical institutions and competent authorities, the Insurer has the right to extend the time for consideration of documents for decision-making and in writing request additional documents (or copies thereof) from the Insured Person, Service Company, medical institutions and/or competent authorities, and also has the right to conduct an independent investigation.

4.20.1. If the recipient of the insurance benefit is not a person who has applied to the Insurer with an application for an insurance benefit, it is necessary to provide a document certifying the identity of the recipient of the payment. In this case, the decision-making period (the single term for the settlement of the claim for insurance payment) begins to be calculated from the date of receipt by the Insurer of this document.

4.20.2. If the Insurer identifies the fact that the applicant has provided documents insufficient for the Insurer to make a decision on the insurance payment and (or) improperly executed in accordance with the requirements of these Insurance Rules and (or) the Insurance Contract, the Insurer accepts the documents and notifies the applicant within 15 (fifteen) working days about the missing and (or) improper properly executed documents.

4.20.3. If the person who applied for the insurance payment fails to provide bank details, as well as other information necessary for making the insurance payment in a non-cash manner, the period for making the insurance payment is suspended until the Insurer receives the specified information. The Insurer notifies about the fact of suspension of the terms of the insurance payment in writing by the method specified by the policyholder in the application for insurance payment.

4.20.4. The deadline for making a decision on insurance payment does not begin to be calculated until the applicant provides the last of the necessary and properly executed documents.

4.21. The insurance payment is made within 10 working days from the date of the Insurer's decision to recognize the event as an insured event and the insurance payment.

4.21.1. The insurance payment made directly to the Insured Person is carried out by transferring funds to the bank account specified by the Insured Person. The payment date is the date when funds are debited from the Insurer's

account.

The costs of crediting to the account and receiving (debiting) from the recipient's account of the amounts to be paid are carried out at the expense of the recipient's funds.

4.21.2. Insurance payments made by paying the bills of the Service Company or the organization that provided the services are made in accordance with the conditions of the contract concluded between the Insurer and the Service Company.

5. INSURANCE TERRITORY

5.1. Insurance territory is the territory covered by the Insurance Contract.

5.2. The Insurance territory for risks "Medical and other emergency expenses", "Accident", "Loss of baggage", "Civil liability" is indicated in the Insurance Policy at the choice of the Policyholder, depending on the route of travel of the Insured person.

5.3. The Insurance territory for the "Cancellation of the trip" risk is only the Russian Federation, even if the Insurance Policy specifies a different territory.

5.4. In any case, Insurance territory does not include the following:

- the place of permanent residence of the Insured person;

- open sea (i.e. the sea outside territorial waters);

- Arctic and Antarctic territories;

- countries on whose territory military operations are being conducted (armed conflicts, special operations, etc.), outbreaks of epidemics have been detected and recognized, are zones of natural disasters; states against which UN military sanctions have been applied, states recognized by the Government of the Russian Federation or other state authorities as undesirable for citizens of the Russian Federation to visit, as well as states, where, with a high probability, harm can be done to human life and health. Information on the territories listed in this subparagraph is published on the official websites of the Ministry of Foreign Affairs of the Russian Federation, the Ministry of Health of the Russian Federation, Rospotrebnadzor, Rosturizm and official sources of the executive power of the Russian Federation.

6. CONCLUSION AND TERMINATION OF THE INSURANCE CONTRACT. INSURANCE PERIOD

6.1. The Insurance Contract is concluded on the basis of a written or oral statement of the Policyholder's intention to conclude an Insurance Contract upon presentation to the Insurer of the identity document of the Policyholder (Insured Person).

6.2. When concluding an Insurance Contract, the Policyholder shall inform the Insurer of the information specified in clause 6.3. of the Insurance Rules:

6.3. If after the conclusion of the Insurance Contract it is established that the Policyholder has provided knowingly false information about circumstances that are essential for determining the probability of an insured event and the amount of possible losses from its occurrence, the Insurer has the right to demand that the Insurance Contract be declared invalid and the consequences be applied in accordance with the legislation of the Russian Federation, except for the case when the circumstances about which the Policyholder has kept silent, have already disappeared.

6.4. When concluding an Insurance Contract, an agreement shall be reached between the Policyholder and the Insurer on the following essential conditions:

- object of insurance;
- nature of the event, in case of occurrence of which insurance is carried out (insured event);
- amount of the insured amount;
- validity period of the Insurance Contract and the insurance period.

6.5. The insurance contract is concluded in the form of an offer. At the same time, on the basis of Articles 435; 438 of the Civil Code of the Russian Federation, the consent of the Policyholder to conclude an insurance contract on the terms proposed by the Insurer is confirmed by the acceptance of the insurance contract from the Insurer, and the payment of the insurance premium is considered acceptance (consent to conclude an insurance contract).

6.6. The insurance policy is signed by an authorized employee of the Insurer indicating his/her surname, first name, patronymic, position, number of the power of attorney and the date of its issue (or other document on the basis of which the authorized person acts).

6.7. In accordance with Article 160 of the Civil Code of the Russian Federation, an insurance Policy may be certified by a facsimile seal and signature of a person authorized to sign an insurance contract on behalf of the Insurer, using mechanical or other means of copying an electronic digital signature, or another analogue of a handwritten signature. The Policyholder's agreement with the terms of the Insurance Contract, with the terms of these Rules (conditions, insurance programs), as well as with the facsimile signature of the Insurer is certified by the signature of the Policyholder in the insurance Policy and/or payment of the insurance premium.

6.8. By entering into an Insurance Contract on the basis of these Insurance Conditions, the Policyholder confirms his consent in accordance with Federal Law No. 152-FZ of 27.07.2006 "On Personal Data" to the processing by the Insurer of the personal data of individuals specified in it during the entire term of the Insurance Contract. The Policyholder is personally responsible for providing the consent of individuals – Insured persons and Beneficiaries to the processing of their personal data.

6.8.1. The processing of personal data is understood as: collection, systematization, accumulation, storage, clarification (updating, modification), use, depersonalization, blocking, destruction, as well as performing other actions with personal data of individuals for statistical purposes and for the purpose of analyzing insurance risks.

6.8.2. By entering into an Insurance Contract, the Policyholder also confirms consent to be informed about other products and services, as well as about the conditions for extending legal relations with the Insurer. For the above purposes, the Insurer has the right to transfer personal data, that became known to him/her in connection with the conclusion and execution of the Insurance Contract, to third parties with whom the Insurer has concluded relevant agreements ensuring reliable storage and prevention of illegal disclosure (confidentiality) personal data.

6.8.3. The Insurer undertakes to ensure the safety and non-disclosure of the personal data of the Policyholder (Insured Person) for purposes other than those provided for in this paragraph. Consent to the processing of personal data may be revoked by the subject of personal data in full or in part of informing about other products and services by sending a written application to the Insurer in a way that allows to reliably establish the date of receipt of this application by the Insurer.

6.8.4. In case of complete withdrawal by the subject of personal data of his/her consent to the processing of personal data, the Insurance Contract with respect to such a person is terminated, and in case of withdrawal of such consent by the subject of personal data, who is the Policyholder, the Insurance Contract is terminated in full. In this case, the Insurance Contract is terminated prematurely from the date of receipt by the Insurer of the relevant application for revocation of consent to the processing of personal data.

6.8.5. If the subject of personal data withdraws consent to the processing of his/her personal data, the Insurer undertakes to stop processing them and, if the storage of personal data is no longer required for the purposes of processing personal data, to destroy personal data within the period prescribed by law from the date of receipt by the Insurer of the specified recall.

6.9. In case of conclusion of a Contract with a person deprived of legal capacity, such an Insurance Contract is considered invalid from the moment of its conclusion.

6.10. The insurance contract may provide for additional restrictions on the admission to insurance of certain categories of individuals related to their age, health status, living conditions, professional or other activities.

6.11. By entering into an Insurance Contract, the Policyholder (Insured Person) agrees to the access of the Insurer and/or the Service Company or their representatives to any information about his/her health status, medical services provided, to familiarize himself/herself with medical documentation, to receive copies of these documents, and also releases doctors/Clinic from the obligations of medical secrecy and confidentiality to the Insurer.

6.12. An Insurance Contract with the inclusion of the "Cancellation of the trip" risk can be concluded no later than 2 (two) working days from the date of conclusion of the contract on the sale of tourist products, for independent travel — no later than 2 (two) working days from the date of payment of travel documents and/or the date of payment for hotel accommodation.

In case of an increase in the cost of tourist services or the purchase of additional services, the Policyholder has the right to conclude an Insurance Contract for the "Cancellation of a trip" risk for the amount of an increase in the cost of a tourist product within two days from the date of signing the relevant supplementary agreement to the contract on the sale of a tourist product.

6.13. An Insurance Contract with respect to risks other than "Cancellation of a trip" may be concluded before the start of such a trip or during the stay of the Insured Person in the insurance territory, at the same time:

6.13.1. The insurance period for Contracts concluded during the Insured Person's stay in the insurance territory begins after 5 (five) calendar days, calculated from the date of conclusion of the Insurance Contract.

Under contracts concluded during the Insured Person's stay in the insurance territory, the Insurer is not liable for any losses, expenses and/or liability arising before the commencement of the insurance period, as well as for any consequences of events that occurred before the commencement of the insurance period, regardless of whether such events and/or their consequences have insurance signs under these Conditions of Insurance or not.

6.15. The insurance contract can be concluded for a specific trip or several trips (MULTI, MULTI 1, MULTI 2 programs) during the term of the Insurance Contract.

6.15.1. The insurance contract with the inclusion of the "Cancellation of the trip" risk is concluded only for a specific trip.

6.16. The term of the Insurance Contract and the insurance period are established by agreement of the parties in each specific case and are specified in the Insurance Contract (Insurance Policy).

6.17. Insurance period is the period within the validity period of the Insurance Contract during which the Insurer is liable under the Insurance Contract.

6.17.1. The insurance period is calculated by the number of days of the Insured Person's expected stay in the Insurance Territory, and is indicated in the insurance Policy in the column "Number of days".

6.17.2. At each entry of the Insured Person into the Insurance Territory, the insurance period specified in the column "Number of days" is automatically reduced by the number of days spent by the Insured Person in the Insurance Territory.

6.17.3. For MULTI programs, the maximum duration of one trip is set:

- According to the MULTI insurance program, the maximum duration of 1 (one) trip covered by insurance is 15 days.

- According to the MULTI 1 insurance program, the maximum duration of 1 (one) trip covered by insurance is 30 days.

- According to the MULTI 2 insurance program, the maximum duration of 1 (one) trip covered by insurance is 90 days.

For all MULTI category programs, 1 (one) trip means: departure of the Insured person outside the country/place of permanent residence to the insurance territory specified in the contract and stay in the specified insurance territory until returning to the territory of the country/place of permanent residence.

6.18. Departure of the Insured person during his/her stay in the insurance territory to a territory that is not, under the terms of the contract, an insurance territory and a place of permanent residence, and subsequent entry into the insurance territory does not interrupt this trip and, accordingly, is not a new trip.

6.18. The Insurance Contract comes into force from the date of payment of the insurance premium by the Policyholder.

6.19. In case of loss of the Insurance Policy, the Insurer issues the Policyholder a duplicate of the Insurance Policy.

6.20. The Insurance Contract is concluded for a period not less than the period of stay of the Insured Person in the insurance territory specified by the Policyholder.

6.21. Insurance for the risks of "Medical and other emergency expenses", "Accident", "Loss of baggage", "Civil liability" begins on the day specified in the Insurance Policy as the commencement date of the Insurance Contract (subject to payment of the insurance premium), but not earlier:

6.21.1. when traveling abroad, citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship — from the moment the Insured person crosses the border of the country that is the insurance territory, which is confirmed by the mark of the border services in the passport, and are valid until the Insured passes border control when leaving the insurance territory, but not later than the date of expiry of the insurance period;

6.21.2. when traveling on the territory of the Russian Federation of foreign citizens — from the moment the Insured person crosses the border of the Russian Federation upon entry into the territory of the Russian Federation, which is confirmed by the mark of the border services in the passport, and are valid until the Insured passes border control

when leaving the territory of the Russian Federation, but not later than the expiration date of the insurance period;

6.21.3. when traveling on the territory of the Russian Federation of citizens of the Russian Federation — from the moment the Insured person crosses (leaves) the administrative border of the settlement of the permanent place of his/her residence, and are valid until the moment the Insured Person crosses (enters) the administrative border of the settlement of his/her permanent place of residence at the end of the trip, but no later than the end date of the insurance period.

6.22. The insurance period for the "Cancellation of the trip" risk begins at 00:00 on the day following the day specified in the insurance Policy as the date of conclusion of the Insurance Contract and is valid:

- when traveling abroad of the Russian Federation — until the Insured person passes border control when leaving the border of the Russian Federation (which is confirmed by the mark of the border services in the passport), but not later than the beginning of the insurance period specified in the insurance policy for the "Medical and other emergency expenses" or "Accident" risks;

- when traveling on the territory of the Russian Federation — until the moment when the Insured Person crosses (leaves) the administrative border of the settlement of his/her permanent residence, but not later than the commencement date of the insurance period specified in the insurance policy for the "Medical and other emergency expenses" or for the "Accident" risks.

6.23. If it is impossible for the Insured Person to return from the insurance territory before the end of the insurance period due to inpatient treatment in consequence of an insured event that occurred during the insurance period, which is confirmed by a medical report, the Insurer fulfills its obligations under this insured event regardless of the expiration date of the Insurance Contract, but not more than 10 calendar days from the date of termination of the insurance, after which the Insurer's obligations cease in full, including reimbursement of expenses for the return of the Insured to the place of permanent residence, medical transportation or repatriation of the body.

6.24. If the insurance period specified in the insurance Policy expires before the end of the trip (that is, during the Insured's stay in the insurance territory), the Policyholder has the right to apply in writing to the Insurer with an application for an extension of the insurance period. Such an application shall be received by the Insurer no later than 3 days before the expiration of the insurance period specified in the current Insurance Contract. In this case, if the Insurer agrees to extend the insurance period, a new Insurance Contract is drawn up, the insurance period for which begins on the day following the day of termination of the previous Insurance Contract.

If the application for the extension of the insurance period was received by the Insurer later than the specified period, as well as in other cases of concluding an Insurance Contract during the stay of the Insured person in the insurance territory, the conditions specified in clause 6.13.1. of these Conditions apply.

6.25. The Insurance Contract is not valid in the territory where military operations, anti-terrorist operations are being conducted, military conflicts, confrontments take place, within which outbreaks of epidemics are detected and officially recognized, even if this territory, according to the Insurance Contract, is the Insurance Territory.

6.26. The Insurance Contract is terminated in the following cases:

6.26.1. Expiration of its validity or insurance period.

6.26.2. Fulfillment by the Insurer of obligations to the Policyholder under the Insurance Contract in full.

6.26.3. Liquidation of the Policyholder, who is a legal entity, or death of the Policyholder, who is a natural person.

6.26.4. Court's decision to declare the Insurance Contract invalid.

6.26.5. If the Insured Person obtains citizenship or a residence permit in a country that is part of the Insurance Territory (the effect is terminated on the territory of the specified country from the moment of obtaining citizenship or a residence permit), except in cases of obtaining a residence permit for education purposes.

6.26.6. In other cases provided for by the current legislation of the Russian Federation.

6.27. The Policyholder has the right to cancel the Insurance Contract at any time.

6.27.1. In case of termination of the Insurance Contract at the request of the Policyholder, the Insurance Contract is considered terminated from the date of submission by the Policyholder of the relevant application, unless a later term for termination of the Insurance Contract is specified in the Policyholder's application.

6.27.2. To terminate the Insurance Contract, the Policyholder shall send an application for termination of the Insurance Contract in the form of the Insurer, personally signed by the Policyholder and the documents specified in

the application, via the application form on the Insurer's website or by mail to the Insurer. Upon receipt of unsigned and not properly executed applications and documents to them, the Insurer has the right to request from the Policyholder documents duly executed within no later than 10 (ten) working days from the date of receipt by the Insurer of the application. When requesting documents, the Insurer suspends consideration of the Policyholder's application for termination of the Insurance Contract and resumes the review process from the date of receipt of the documents duly executed.

6.27.3. The refund of the paid insurance premium to the Policyholder is made on the basis of the following documents:

- Insurance Contract (Insurance Policy);

- statements indicating the reason for termination of the Insurance Contract;

- details of the current account of the Policyholder (Insured person). For foreign citizens, it is necessary to provide the details of the current account in US dollars, in euros or in rubles. The costs of crediting to the account and receiving (debiting) from the recipient's account of the amounts to be paid are carried out at the expense of the recipient's funds;

- passport of a citizen of the Russian Federation and/or passport of the Policyholder/Insured person.

6.27.4. If the Policyholder cancels the Insurance Contract before the commencement of the insurance period, the Insurer withholds 35 (thirty-five) percent of the insurance premium paid, except in cases provided for in clauses 6.29 and clause 6.30 of these Terms.

6.27.5. If the Policyholder cancels the Insurance Contract after the commencement of the insurance period, the insurance premium is not refunded, except in cases provided for in clause 6.30 of these Conditions.

6.28. Refund of the insurance premium at the option of the Policyholder is carried out in cash or by bank transfer within 10 working days from the date of receipt by the Insurer of the written application of the Policyholder to cancel the Insurance Contract, subject to the provisions of clause 6.27.2 of these Conditions.

6.29. If the Policyholder cancels the Insurance Contract for the "Cancellation of the trip" risk, the insurance premium is not subject to refund, except in cases provided for in clause 6.30 of these Conditions.

6.30. Policyholder, an individual, has the right to cancel an Insurance Contract that provides for the risks of "Medical and other emergency expenses" (except for Insurance Contracts for travelers traveling outside the Russian Federation concluded only for the risk of "Medical and other emergency expenses"), "Accident", "Civil Liability", "Loss of baggage", "Cancellation of a trip" within 14 calendar days from the date of its conclusion, in the absence of events in this period that have signs of an insured event, with the return by the Insurer of the insurance premium paid by the Policyholder on the following conditions:

- if the Policyholder has canceled the Insurance Contract within 14 calendar days from the date of its conclusion, and before the date of occurrence of the Insurer's obligations under the concluded Insurance Contract (hereinafter referred to as the insurance commencement date), the insurance premium paid is subject to refund to the Policyholder in full.

- if the Policyholder has canceled the Insurance Contract within 14 calendar days from the date of its conclusion, but after the date of commencement of the insurance, the Insurer, when returning the insurance premium paid to the Policyholder, withholds part of it in proportion to the validity period of the Insurance Contract that has elapsed from the date of commencement of the insurance to the date of termination of the Insurance Contract.

In this case, the insurance premium to be refunded is calculated according to the following formula:

$IR = (P1) \times M / N$

where IR is the premium to be refunded; P1 is the total amount of the insurance premium under the Insurance Contract; N is the period of validity of insurance protection in days; M is the non-expired period of insurance protection in days.

6.31. The insurance premium is refunded within 10 working days from the date of receipt by the Insurer of the written application of the Policyholder to cancel the Insurance Contract in cash or in a non-cash manner at the choice of the Policyholder.

The Insurance Contract is considered terminated from 00:00 from the date of receipt by the Insurer of the written application of the Policyholder to cancel the Insurance Contract or another date established by agreement of the

parties, but no later than 14 calendar days from the date of its conclusion.

6.32. The Insurer, at the request of the Policyholder, provides in writing a calculation of the amount of the insurance premium to be refunded, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the calculation was made.

7. RIGHTS AND OBLIGATIONS OF THE PARTIES UNDER THE INSURANCE CONTRACT

7.1 The Policyholder (Insured person) has the right to:

7.1.1. get acquainted with the Conditions of insurance;

7.1.2. require the Insurer to fulfill its obligations under the Insurance Contract;

7.1.3. apply to the Insurer with an application for making changes to the Contract in terms of the essential conditions of insurance with the corresponding recalculation of the insurance premium before the start of the insurance period. In this case, a new Insurance Contract (Insurance Policy) is issued;

7.1.4. get a duplicate of the Insurance Policy in case of its loss;

7.1.5. terminate the Insurance Contract in accordance with the procedure provided for by civil legislation and Insurance Rules;

7.1.6. receive information from the Insurer concerning its financial stability, which is not a trade secret.

7.1.7. without the consent of the Insurer and/or the Service Company, independently pay the costs associated with the insured event, if their amount does not exceed 300 units.

7.1.8. request a copy of the power of attorney of the employee who signed the Insurance Contract (Insurance Policy).

7.2. The Policyholder (Insured person) is obliged to:

7.2.1. at the conclusion of the Insurance Contract, inform the Insurer of reliable information about the person being insured, as well as about all circumstances known to them that are of significant importance for the assessment of the insurance risk;

7.2.2. pay the insurance premium in the amounts and terms determined by the Insurance Contract;

7.2.3. comply with the provisions of these Insurance Conditions;

7.2.4. inform the Insurer during the validity period of the Insurance Contract about the changes in circumstances that have become known to them, which may affect the increase in the insured risk;

7.2.5. act reasonably and take all precautions to avoid an accident or sudden illness;

7.2.6. when carrying out a foreign trip, observe the rules of entry into the country of temporary residence, departure from the country of temporary residence and stay there, as well as in transit countries;

7.2.7. during the trip, observe the legislation of the country of stay, the rules of personal safety and ensure the safety of the insured baggage;

7.2.8. upon the occurrence of events with signs of an insured event, comply with the requirements of the 8, 12, 17, 20, 25, 29-31 sections of these Insurance Conditions regulating the obligations of the Insured Person upon the occurrence of an insured event.

7.3. The Insurer has the right to:

7.3.1. organize the necessary assistance to the Insured Person on the Insurance Territory, involve Service Companies, other organizations authorized by the Insurer;

7.3.2. verify the information provided by the Policyholder (Insured person, Beneficiary), as well as the fulfillment by the Policyholder (Insured Person) of the requirements of the Insurance Contract;

7.3.3. conduct an examination of the Insured person to assess his/her actual state of health;

7.3.4. Recommend to the Policyholder (the Insured person) the following:

- independently apply to one of the official licensed medical institutions for medical assistance in an emergency for vital indications with the involvement of a local emergency medical service for cash with the preservation of all documents on the event that has signs of an insured event, and with subsequent appeal to the Insurer to make a

decision on the issue of reimbursement of funds spent;

- with the referral from the Service Company, contact an official licensed medical institution for the necessary assistance in cash keeping all documents on the event that has signs of an insured event, and then contact the Insurer to make a decision on the issue of reimbursement of the funds spent.

7.3.5. independently find out the causes and circumstances of an event that has signs of an insured event, if necessary, request information from competent authorities, medical institutions, Service companies that have information about the circumstances of the event, as well as independently find out the causes and circumstances of the event;

7.3.6. refuse the insurance payment or reduce its amount if the Policyholder (Insured Person):

- failed to notify the Service Company about the insured event in a timely manner, thereby making it impossible to establish all the circumstances of the insured event;

- did not provide all the documents necessary for making a decision on the payment of insurance compensation, determining its size;

- if the insured event occurred when the Insured Person performed any type of work not provided for in the terms of his/her employment contract (if the profession is indicated in the Insurance Contract);

- if the Policyholder (the Insured Person) has informed the Insurer knowingly false information about his/her health (or about the health of the Insured Person) and/or about the volume and cost of medical services provided, other information necessary for the conclusion of the Insurance Contract.

7.3.7. in case of force majeure, refuse to fulfill the obligations under the Insurance Contract or change the deadline for their fulfillment;

7.3.8. demand to declare the Insurance Contract invalid and apply the consequences provided for by the legislation of the Russian Federation if it is established that the Policyholder/Insured person knowingly provided false information about circumstances that are essential for determining the degree of risk and the amount of loss upon the occurrence of an insured event.

7.3.9. at the "Loss of baggage" risk, check the property interest, receive documents confirming the existence of the property interest from the Policyholder, and verify the authenticity of the documents and the relevance of the information contained therein.

After analyzing the totality of available information and documents, the Insurer concludes that the Policyholder has or has no property interest.

An insurance contract for the property of citizens concluded in the absence of the Policyholder's interest in preserving the insured property is invalid.

7.4. The Insurer is obliged to:

7.4.1. acquaint the Policyholder (Insured persons), as well as persons intending to conclude an insurance contract, with the Conditions of Insurance, Insurance Rules, including by posting them on the Insurer's website at: www.euro-ins.ru/o_kompanii/regulations/.ru, as well as explain the provisions contained in the Insurance Conditions and in the Rules.

7.4.2. to ensure confidentiality in relations with the Policyholder (Insured person);

7.4.3. in cases recognized by the Insurer as insured, make payment of insurance compensation in the manner and within the time limits stipulated by the Insurance Contract and/or these Conditions;

7.4.4. comply with the conditions of the Insurance Contract and the provisions of these Conditions;

7.4.5. upon written request of the Policyholder, provide a calculation of the amount of the insurance premium;

7.4.6. upon an oral or written request of the Policyholder, including received in electronic form, within a period not exceeding 30 days from the date of receipt of such request, subject to the possibility of identification of the Policyholder in accordance with the requirements of Federal Law No. 152-FZ of June 27, 1996 "On Personal Data", the Insurer after making a decision about the insurance payment provides information about the calculation of the amount of the insurance payment, which should include:

- the final amount of insurance compensation to be paid,

- the procedure for calculating the insurance payment;

- a comprehensive list of legal norms and (or) conditions of the insurance contract and (or) these Conditions and/or Insurance Rules, circumstances and documents on the basis of which the calculation was made.

7.4.7. at the written request of the Policyholder, the Insurer, within a period not exceeding 30 days, is obliged to provide him/her in writing with comprehensive information and documents (including copies of documents and (or) extracts from them), on the basis of which the Insurer made a decision on the insurance payment (except for documents that indicate possible illegal actions of the Policyholder aimed at receiving insurance payments), free of charge 1 time for each insured event. The specified information and documents are provided to the extent that it does not contradict the current legislation of the Russian Federation;

7.4.8. inform the Policyholder (Insured person) on issues related to the execution of the Insurance Contract, including:

7.4.8.1. notify the Policyholder of additional conditions for concluding an Insurance Contract (medical examination of the person in respect of whom the contract is concluded) and the possibility of changing the amount of the premium after receiving the results of such an examination;

7.4.8.2. inform the Policyholder about the fact of late payment of the next insurance premium or the fact of its payment not in full, as well as about the consequences of such violations in the manner chosen by the policyholder in the insurance application at the conclusion of the insurance contract (policy). If the insurance contract (policy) is concluded on the basis of an oral application, the notification is sent to the address specified by the policyholder in the insurance contract;

7.4.9. upon receiving a request from the Policyholder, inform him/her about the following:

7.4.9.1. all necessary actions provided for by the contract and (or) Insurance Conditions that the Policyholder shall take, and about all documents that shall be provided for consideration of the issue of recognizing the event as an insured event and determining the amount of the insurance payment, as well as about the timing of these actions and submission of documents;

7.4.9.2. the form and methods of insurance payment provided for in the contract and these Insurance Conditions and the procedure for changing them, aimed at ensuring the rights of the Policyholder to receive insurance payment in a convenient way for him/her from among those specified in the Insurance Contract;

7.4.10. if there are no legal grounds for making an insurance payment, the Insurer shall inform the Policyholder (Beneficiary, Insured Person) thereof within the time limits and in accordance with the procedure provided for in clause 3.8. of these Conditions.

7.4.11. when concluding an Insurance Contract, the Insurer informs the Policyholder about the addresses of the places where documents are received, upon the occurrence of events that have signs of an insured event, as well as timely changes to such addresses, including, but not limited to, on the official website of the Insurer www.euro-ins.ru;

7.5. All notifications sent to the Policyholder (Insured Person) by the Insurer are considered to have been made properly if they are sent:

- info@euro-ins.ru; by postal communication to the registration address of the Policyholder (Insured person) – an individual, or to another address specified by the Policyholder in the Insurance Contract (Insurance Policy), in additional agreements to it, in the application for insurance payment. If the address is changed, the Policyholder is obliged to notify the Insurer in writing by e-mail to: info@euro-ins.ru;

- by postal communication to the address of registration of the Policyholder – a legal entity, or to another address specified by the Policyholder in the Insurance Contract (Insurance Policy), in additional agreements to it, in the application for insurance payment. If the address is changed, the Policyholder is obliged to notify the Insurer in writing by e-mail to: info@euro-ins.ru. In any case, a notification sent to the location of the Policyholder specified in the Unified State Register of Legal Entities on the date of sending the notification is considered appropriate;

- by e-mail to the address of the Policyholder (Insured Person) specified by the Policyholder in the Insurance Contract (Insurance Policy), in additional agreements to it, in the application for insurance payment. If the e-mail address is changed, the Policyholder is obliged to notify the Insurer in writing by e-mail to: info@euro-ins.ru;

- by telephone to the mobile phone number of the Policyholder (Insured Person) specified by the Policyholder in the Insurance Contract (Insurance Policy), in additional agreements to it, in the application for insurance payment. If the phone number is changed, the Policyholder is obliged to notify the Insurer in writing by e-mail to: info@euro-ins.ru;

8. General obligations of the parties in case of events that have signs of an insured event.

8.1. Upon the occurrence of an event that has the signs of an insured event, the Policyholder (Insured person) is obliged to:

8.1.1. take reasonable and affordable measures in the circumstances to reduce possible costs, and act as if they were not insured;

8.1.2. immediately notify the Service Company and the Insurer of the event by the phone numbers specified in the Insurance Contract (Insurance Policy) to ensure that they are able to organize the necessary assistance in a timely manner, issue the necessary recommendations, etc.;

8.1.3. strictly follow the instructions of the Service Company and the Insurer, prescriptions of authorized doctors;

8.1.4. fulfill the obligations stipulated by these Insurance Conditions for the circumstances, depending on the type of event (type of insurance risk);

8.1.5. be available for communication with the Service Company's round-the-clock center using possible communication methods;

8.1.6. provide the Insurer and/or its Representative (Service company, medical institution, etc.), upon their request, with written permission to receive information from medical and other institutions and assist in obtaining them.

8.2. When applying for assistance provided for in the Insurance Contract, the Insured Person (their representative) and/or the Policyholder are obliged to provide, among other things, the following information:

- surname, name of the Insured person, his/her location and telephone number for communication;

- number of the Insurance Contract (Insurance Policy), its validity period, the name of the Insurer;

- time and circumstances of the incident, the type of assistance required;

- other information requested by the representative of the Service Company or the Insurer, including the document that is the basis for staying in the insurance territory (visa of the country of stay, temporary residence permit, etc.), copies of all pages of the passport.

8.3. After receiving a notification of the occurrence of an event that has signs of an insured event, the Insurer is obliged to:

8.3.1. ensure the fulfillment of its obligations under the Insurance Contract;

8.3.2. find out the circumstances of the occurrence of the event;

8.3.3. after receiving all the necessary documents, when recognizing an event as an insured event, draw up an insurance report and calculate the amount of the insurance payment in the manner and within the time limits provided for by these Conditions;

8.3.4. Identify the Beneficiary when settling the loss, if the Insurance Contract provides for its conclusion without specifying the surname, first name, patronymic (if any) of the Beneficiary (third parties, heirs by law);

8.3.5. Make an insurance payment (or report a refusal to pay, if there are grounds) within the period established by the Insurance Contract and the Insurance Rules.

SECTION II. RISK "MEDICAL AND OTHER EMERGENCY EXPENSES"

9. The insured event for the "Medical and other emergency expenses" risk are expenses (losses) for payment of medical care in emergency and urgent forms, including medical evacuation of the Insured Person, and other emergency expenses incurred due to injury, poisoning, sudden acute illness or exacerbation of a chronic disease, death of the Insured person as a result of a sudden illness, injuries or poisoning that occurred during the stay in the insurance territory.

10. According to the "Medical and other emergency expenses" risk, expenses are subject to payment/reimbursement in the amount provided for by the Insurance Program chosen by the Policyholder and specified in the insurance Policy.

10.1. Insurance program A (Economy)

According to the A (Economy) program, the following expenses are subject to payment/reimbursement:

10.1.1. Medical care in emergency and urgent forms in the following amount:

10.1.1.1. consultation of a general practitioner and/or a specialist; urgent and emergency diagnostic tests prescribed by the attending physician, outpatient treatment (subject to the exceptions listed in clause 11 of these Insurance Conditions); medicines prescribed by the attending physician, dressings;

If the Insurance Contract specifies the insurance program A and more than 90 days are indicated in the column "Number of insured days", then no more than 2 visits to the doctor for each insured event are paid.

10.1.1.2. hospital stay and treatment, including operations (subject to the exceptions listed in clause 11 of these Insurance Conditions); diagnostic tests for emergency indications followed by the appointment of treatment; medications prescribed by the attending physician, dressings;

The Insurer has the right to refuse to reimburse the medical and diagnostic procedures recommended by the attending physician if, in the opinion of the doctor appointed by the Insurer, they are not emergency or can be replaced by other diagnostic tests. An expert doctor appointed by the Service Company and/or the Insurer shall have free access to the Insured Person and the opportunity to get acquainted with his/her medical record.

10.1.1.3. emergency dental care in case of acute toothache and injuries of natural teeth. In this case, the Insurer reimburses only the expenses of the Insured Person for: local anesthesia, targeted radiography of the tooth, the imposition of devitalizing agents in acute or exacerbation of chronic pulpitis, tooth extraction in exacerbations of chronic periodontitis, periostitis, parodontitis, pulpitis, autopsy and drainage of inflammatory infiltrate. Expenses for emergency dental care under Program A are reimbursed within:

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 200 conventional units for the entire insurance period established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 200 conventional units for the entire period of insurance established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 3,000 rubles for the entire insurance period established by the Insurance Contract;

10.1.1.4. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical care in emergency and urgent form** is 40,000 units.

10.1.2. Medical evacuation in the following extent:

10.1.2.1. transportation in any accessible and expedient way in conditions that threaten the life of the Insured person to the nearest medical institution for emergency medical care. At the same time, the costs of transporting the Insured Person by helicopter are reimbursed within only 5,000 (five thousand) units. The return transportation from the medical institution is not paid. Any complications or negative consequences for the health of the Insured as a result of improper transportation carried out by any means other than specialized medical transport and/or transport agreed with the Service Company or the Insurer are not covered;

10.1.2.2. transportation of the Insured person with the necessary escort from the medical institution to which he/she was taken from the scene of the accident to a medical institution equipped to treat the injuries he/she received or this particular disease;

10.1.2.3. transportation with the necessary medical support (if such transportation is required for medical reasons) to the international transport hub of the country of permanent residence - when traveling abroad or to the transport hub (airport, train station, port) closest to the place of permanent residence of the Insured - when traveling across the territory of the Russian Federation.

When carrying out transportation, the Service Company (or the Insurer) has the right to use the return ticket of the Insured Person at its discretion (including handing it over to a transport organization, exchanging it, etc.). At the same time, the Insured Person should not prevent the Service Company (or the Insurer) from exercising this right.

The necessity and method of transportation and medical support is determined jointly by the attending physician, the representative (doctor) of the Service Company and the representative of the Insurer. Air ambulance is used in exceptional cases if the condition of the Insured person does not allow the use of other vehicles. An expert doctor appointed by the Service Company and/or the Insurer should have free access to the Insured Person and the opportunity to get acquainted with his/her medical record;

10.1.2.4. transportation of the Insured person from the insurance territory with the necessary medical support to a

suitable hospital nearest to the place of permanent residence of the Insured person, if his/her condition allows such transportation (evacuation), if the estimated costs of treating the Insured person in the insurance territory exceed the costs of evacuation. The attending physician or the medical representative of the Service Company shall determine whether the condition of the Insured person allows him/her to be evacuated as an ordinary passenger or appropriate preparatory measures (devices, means) are necessary;

10.1.2.5. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical evacuation** is set at 40,000 units.

10.1.3. Other emergency expenses in the following amount:

10.1.3.1. Phone calls to the Service Company and/or the Insurer.

The costs of telephone conversations with the Service Company and/or the Insurer are reimbursed, provided that the event that occurred is recognized as an insured event. The telephone bill shall contain the following data: the date of the call, the phone number, the duration of the conversation, the cost of the conversation. The Policyholder (Insured person) shall present a document confirming the payment of this bill.

10.1.3.2. Repatriation of the body in case of death of the Insured person as a result of sudden illness, injury and/or poisoning.

In case of death of the Insured person, the Insurer pays for the organization of the repatriation of the body by the Service Company, as well as pays for the costs agreed and authorized by the Service Company for the autopsy and embalming of the body, the stay of the body in the morgue, for the purchase of the coffin required for transportation, registration of documents necessary for transportation, transportation of the body to the international transport hub of the country of permanent residence – in case of trips abroad or to a transport hub (airport, train station, port) closest to the Insured Person's place of permanent residence - when traveling on the territory of the Russian Federation.

The repatriation of the body is carried out in accordance with international standards.

Funeral and burial expenses are not reimbursed.

10.1.3.3. If in the insurance contract the amount of 100,000 unit is indicated in the column "Insurance amount", then the aggregate limit of compensation for **Other emergency expenses** is 20,000 units.

10.1.3.4. If the insurance contract in the column "Insurance amount" indicates the amount of 120,000 units, then the aggregate limit of compensation for **Other emergency expenses** is set at 40,000 units.

10.2 Insurance Program B (Standard)

According to Program B (Standard), the following expenses are subject to payment/reimbursement:

10.2.1. Medical care in emergency and urgent forms in the following amount are payable/reimbursed:

10.2.1.1. consultation of a general practitioner and/or a specialist; urgent and emergency diagnostic tests prescribed by the attending physician, outpatient treatment (subject to the exceptions listed in clause 11 of these Insurance Conditions); medicines prescribed by the attending physician, dressings;

10.2.1.2. hospital stay and treatment, including operations (subject to the exceptions listed in clause 11 of these Insurance Conditions); diagnostic tests for emergency indications followed by the appointment of treatment; medications prescribed by the attending physician, dressings;

The Insurer has the right to refuse to reimburse the medical and diagnostic procedures recommended by the attending physician if, in the opinion of the doctor appointed by the Insurer, they are not emergency or can be replaced by other diagnostic tests. An expert doctor appointed by the Service Company and/or the Insurer shall have free access to the Insured Person and the opportunity to get acquainted with his/her medical record.

10.2.1.3. emergency dental care in case of acute toothache and injuries of natural teeth. In this case, the Insurer reimburses only the expenses of the Insured Person for: local anesthesia, targeted radiography of the tooth, the imposition of devitalizing agents in acute or exacerbation of chronic pulpitis, tooth extraction in exacerbations of chronic periodontitis, periostitis, parodontitis, pulpitis, autopsy and drainage of inflammatory infiltrate. Expenses for emergency dental care under Program B are reimbursed within:

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 200 conventional units for the entire insurance period established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 200 conventional units for the entire period of insurance established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 3,000 rubles for the entire insurance period established by the Insurance Contract;

10.2.1.4. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical care in emergency and urgent form** is 50,000 units.

10.2.2. Medical evacuation in the following extent:

10.2.2.1. transportation in any accessible and expedient way in conditions that threaten the life of the Insured person to the nearest medical institution for emergency medical care. At the same time, the costs of transporting the Insured Person by helicopter are reimbursed within only 5,000 (five thousand) units. The return transportation from the medical institution is not paid. Any complications or negative consequences for the health of the Insured as a result of improper transportation carried out by any means other than specialized medical transport and/or transport agreed with the Service Company or the Insurer are not covered;

10.2.2.2. transportation of the Insured person with the necessary escort from the medical institution to which he/she was taken from the scene of the accident to a medical institution equipped to treat the injuries he/she received or this particular disease;

10.2.2.3. transportation with the necessary medical support (if such transportation is required for medical reasons) to the international transport hub of the country of permanent residence - when traveling abroad or to the transport hub (airport, train station, port) closest to the place of permanent residence of the Insured - when traveling across the territory of the Russian Federation.

When carrying out transportation, the Service Company (or the Insurer) has the right to use the return ticket of the Insured Person at its discretion (including handing it over to a transport organization, exchanging it, etc.). At the same time, the Insured Person should not prevent the Service Company (or the Insurer) from exercising this right.

The necessity and method of transportation and medical support is determined jointly by the attending physician, the representative (doctor) of the Service Company and the representative of the Insurer. Air ambulance is used in exceptional cases if the condition of the Insured person does not allow the use of other vehicles. An expert doctor appointed by the Service Company and/or the Insurer should have free access to the Insured Person and the opportunity to get acquainted with his/her medical record;

10.2.2.4. transportation of the Insured person from the insurance territory with the necessary medical support to a suitable hospital nearest to the place of permanent residence of the Insured person, if his/her condition allows such transportation (evacuation), if the estimated costs of treating the Insured person in the insurance territory exceed the costs of evacuation. The attending physician or the medical representative of the Service Company shall determine whether the condition of the Insured person allows him/her to be evacuated as an ordinary passenger or appropriate preparatory measures (devices, means) are necessary;

10.2.2.5. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical evacuation** is set at 30,000 units.

10.2.3. Other emergency expenses in the following amount:

10.2.3.1. Phone calls to the Service Company and/or the Insurer.

The costs of telephone conversations with the Service Company and/or the Insurer are reimbursed, provided that the event that occurred is recognized as an insured event. The telephone bill shall contain the following data: the date of the call, the phone number, the duration of the conversation, the cost of the conversation. The Policyholder (Insured person) shall present a document confirming the payment of this bill.

10.2.3.2. Repatriation of the body in case of death of the Insured person as a result of sudden illness, injury and/or poisoning.

In case of death of the Insured person, the Insurer pays for the organization of the repatriation of the body by the Service Company, as well as pays for the costs agreed and authorized by the Service Company for the autopsy and embalming of the body, the stay of the body in the morgue, for the purchase of the coffin required for transportation, registration of documents necessary for transportation, transportation of the body to the international transport hub of the country of permanent residence – in case of trips abroad or to a transport hub (airport, train station, port) closest to the Insured Person's place of permanent residence - when traveling on the territory of the Russian Federation.

The repatriation of the body is carried out in accordance with international standards.

Funeral and burial expenses are not reimbursed.

10.2.3.3. Return of the Insured Person from the insurance territory if, due to treatment in consequence of the insured event, the Insured Person cannot leave the insurance territory on a scheduled return flight, namely: the costs of purchasing an economy class return ticket to the airport/railway station/port specified in the initial return ticket of the Insured Person, as well as the costs of the Insured Person for accommodation in the amount of:

- when traveling outside the Russian Federation, citizens of the Russian Federation and foreign citizens traveling outside the place of permanent residence - no more than 80 conventional units per day from the moment of discharge from the hospital until the date of departure from the insurance territory, but no more than 5 days.

- when traveling on the territory of the Russian Federation of foreign citizens – no more than 100 conventional units per day from the moment of discharge from the hospital until the date of departure to the place of permanent residence, but no more than 5 days.

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - no more than 1,500 rubles/day from the moment of discharge from the hospital until the date of departure to the place of permanent residence, but no more than 5 days.

At the same time, the Insurer does not pay for the meals of the Insured Person, as well as any expenses of the accompanying person.

10.2.3.4. A visit by a third party in an emergency.

If the health condition of the Insured Person is assessed by the attending physician and the medical representative of the Service Company as critical, with a possible fatal outcome, the Insurer reimburses the cost of direct and return tickets in an economic or equivalent class for one relative of the Insured person. At the same time, the costs of accommodation and meals of a relative (another person) are not reimbursed.

10.2.3.5. Evacuation of minor children accompanying the Insured person.

Expenses for transportation to the country of permanent residence of minor children (under 18 years old) of the Insured person, who remained in the insurance territory without guardianship as a result of an insured event with the Insured Person, are reimbursed. In this case, the cost of the ticket (air, railway) by the economic or equivalent class agreed with the Insurer by the mode of transport (if necessary, with an accompanying person provided by the carrier or the Insurer) is reimbursed.

Transportation can only be arranged by a Service Company and only if the minor child has his/her own passport (if he/she is outside the country of permanent residence) and a power of attorney from the parents for such transportation.

10.2.3.6. Providing an interpreter:

Expenses for the services of an interpreter engaged for the purpose of establishing a diagnosis to an Insured person staying in a hospital are reimbursed. The interpreter is engaged by the Service Company, provided that the medical institution grants such permission.

10.2.3.7. Expenses related to the loss/theft of documents resulting from a sudden illness, injury or poisoning of the Insured person during a temporary stay in the insurance territory.

The costs of the consular fee for the registration of a foreign passport are reimbursed instead of the lost/stolen one. The service company provides advisory information necessary for processing duplicates, lost/stolen documents, without which it is impossible to return to the country of permanent residence.

10.2.3.8. Search and rescue measures to locate the Insured Person in the mountains, at sea, in the desert, in the jungle or other remote areas, including the costs of air/sea search and evacuation to shore from the ship or from the sea.

The maximum amount of compensation for the costs of search and rescue measures is:

- when traveling outside the Russian Federation of Russian citizens and foreign citizens traveling outside the place of permanent residence - up to 3,000 conventional units for the entire period of searches;

- when traveling on the territory of the Russian Federation of foreign citizens – no more than 3,000 conventional units for the entire period of searches;

- when traveling on the territory of the Russian Federation of Russian citizens - no more than 50,000 rubles for the entire search period.

Expenses for search and rescue activities are reimbursed only in cases when the burden of expenses is borne by the Insured Person (his/her close relatives or representatives) and subsequently is not compensated at the expense of the state or private organizations and individuals, and provided that the following risks are included in the Insurance Contract (Insurance Policy): winter active rest, extreme rest, sports, professional activity, children's sports camp.

10.2.3.8. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units, then the aggregate limit of compensation for **Other emergency expenses** is 20,000 units.

10.2.3.9. If the insurance contract in the column "Insurance amount" indicates the amount of 120,000 units, then the aggregate limit of compensation for **Other emergency expenses** are set at 40,000 units.

10.3. Insurance program C

10.3.1. Under Program C, the expenses for the repatriation of the body are payable/reimbursed in the event of the death of the Insured Person as a result of sudden illness, injury and/or poisoning.

In case of death of the Insured person, the Insurer pays for the organization of the repatriation of the body by the Service Company, as well as pays for the costs agreed and authorized by the Service Company for the autopsy and embalming of the body, the stay of the body in the morgue, for the purchase of the coffin required for transportation, registration of documents necessary for transportation, transportation of the body to the international transport hub of the country of permanent residence – in case of trips abroad or to a transport hub (airport, train station, port) closest to the Insured's place of permanent residence - when traveling on the territory of the Russian Federation.

The repatriation of the body is carried out in accordance with international standards.

Funeral and burial expenses are not reimbursed.

10.4. Insurance programs MULTI, MULTI-1

According to the MULTI, MULTI-1 programs, the following expenses are subject to payment/reimbursement:

10.4.1. Medical care in emergency and urgent forms in the following amount:

10.4.1.1. consultation of a general practitioner and/or a specialist; emergency diagnostic tests and treatment prescribed by the attending physician (subject to the exceptions listed in clause 11 of these Insurance Conditions); medications prescribed by the attending physician, dressings;

Under the **MULTI** program, in case of injury the Insurer pays for no more than two bandages for each insured event, in case of poisoning and sudden illness - for no more than two visits to the doctor for each insured event.

10.4.1.2. hospital stay and treatment, including operations (subject to the exceptions listed in clause 11 of these Insurance Conditions); diagnostic tests for emergency indications followed by the appointment of treatment; medications prescribed by the attending physician, dressings;

The Insurer has the right to refuse to reimburse the medical and diagnostic procedures recommended by the attending physician if, in the opinion of the doctor appointed by the Insurer, they are not emergency or can be replaced by other diagnostic tests. An expert doctor appointed by the Service Company and/or the Insurer shall have free access to the Insured Person and the opportunity to get acquainted with his/her medical record.

10.4.1.3. emergency dental care in case of acute toothache and injuries of natural teeth. In this case, the Insurer reimburses only the expenses of the Insured Person for: local anesthesia, targeted radiography of the tooth, the imposition of devitalizing agents in acute or exacerbation of chronic pulpitis, tooth extraction in exacerbations of chronic periodontitis, periostitis, parodontitis, pulpitis, autopsy and drainage of inflammatory infiltrate.

Expenses for emergency dental care are reimbursed:

1) **According to the MULTI program:**

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 100 conventional units for the entire insurance period established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 120 conventional units for the entire period of insurance established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 2,000 rubles for the entire insurance period established by the Insurance Contract;

2) **According to the MULTI 1 program:**

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 200 conventional units for the entire insurance period established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 200 conventional units for the entire period of insurance established by the Insurance Contract;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 3,000 rubles for the entire insurance period established by the Insurance Contract;

10.1.4.4. If the Insurance Contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical care in emergency and urgent forms** is set at 40,000 units.

10.4.2. Medical evacuation in the following extent:

10.4.2.1. transportation in any accessible and expedient way in conditions that threaten the life of the Insured person to the nearest medical institution for emergency medical care. At the same time, the costs of transporting the Insured Person by helicopter are reimbursed within only 5,000 (five thousand) units. The return transportation from the medical institution is not paid. Any complications or negative consequences for the health of the Insured as a result of improper transportation carried out by any means other than specialized medical transport and/or transport agreed with the Service Company or the Insurer are not covered;

10.4.2.2. transportation of the Insured person with the necessary escort from the medical institution to which he/she was taken from the scene of the accident to a medical institution equipped to treat the injuries he/she received or this particular disease;

10.4.2.3. transportation with the necessary medical support (if such transportation is required for medical reasons) to the international transport hub of the country of permanent residence - when traveling abroad or to the transport hub (airport, train station, port) closest to the place of permanent residence of the Insured - when traveling across the territory of the Russian Federation.

When carrying out transportation, the Service Company (or the Insurer) has the right to use the return ticket of the Insured Person at its discretion (including handing it over to a transport organization, exchanging it, etc.). At the same time, the Insured Person should not prevent the Service Company (or the Insurer) from exercising this right.

The necessity and method of transportation and medical support is determined jointly by the attending physician, the representative (doctor) of the Service Company and the representative of the Insurer. Air ambulance is used in exceptional cases if the condition of the Insured person does not allow the use of other vehicles. An expert doctor appointed by the Service Company and/or the Insurer should have free access to the Insured Person and the opportunity to get acquainted with his/her medical record;

10.4.2.4. transportation of the Insured from the insurance territory with the necessary medical support to a suitable hospital closest to the place of permanent residence of the Insured person, if his/her condition allows such transportation (evacuation), if the estimated costs of treating the Insured person in the insurance territory exceed the costs of evacuation. The medical institution and the attending physician or medical representative of the Service Company shall determine whether the condition of the Insured Person allows him/her to be evacuated as an ordinary passenger or appropriate preparatory measures (devices, means) are necessary;

10.4.2.5. If the insurance contract in the column "Insurance amount" indicates the amount of 100,000 units or 120,000 units, then the aggregate limit of compensation for **Medical evacuation** is set at 40,000 units.

10.4.3. Other emergency expenses in the following amount:

10.4.3.1. Phone calls to the Service Company and/or the Insurer.

The costs of telephone conversations with the Service Company and/or the Insurer are reimbursed, provided that the event that occurred is recognized as an insured event. The telephone bill shall contain the following data: the date of the call, the phone number, the duration of the conversation, the cost of the conversation. The Policyholder (Insured person) shall present a document confirming the payment of this bill.

10.4.3.2. Repatriation of the body in case of death of the Insured person as a result of sudden illness, injury and/or poisoning.

In case of death of the Insured person, the Insurer pays for the organization of the repatriation of the body by the Service Company, as well as pays for the costs agreed and authorized by the Service Company for the autopsy and embalming of the body, the stay of the body in the morgue, for the purchase of the coffin required for transportation, registration of documents necessary for transportation, transportation of the body to the international transport hub of the country of permanent residence – in case of trips abroad or to a transport hub (airport, train station, port) closest to the Insured Person's place of permanent residence - when traveling on the territory of the Russian Federation.

The repatriation of the body is carried out in accordance with international standards.

Funeral and burial expenses are not reimbursed.

10.4.3.3. If in the insurance contract the amount of 100,000 units or 120,000 units is indicated in the column "Insurance amount", then the aggregate limit of compensation for **Other emergency expenses** is set at 40,000 units.

10.5. MULTI-2 insurance program

According to the MULTI-2 program, the expenses provided for by the Insurance Program B (clause 10.2. of the Insurance Conditions) are subject to payment/reimbursement.

10.6. Expenses specified in the clauses 10.1.2.2.- 10.1.2.4., 10.2.2.2.-10.2.2.4., 10.4.2.2.-10.4.2.4. of these Insurance Conditions are carried out exclusively by the Service Company or the Insurer, and only in cases where the need for this transportation is confirmed by the conclusion of the attending physician, the Insurer's expert physician and/or the doctor of the Service Company on the basis of documents from the attending physician and provided there are no medical contraindications.

10.7. In case of refusal of the Insured person from transportation (clauses 10.1.2.3, 10.1.2.4, 10.2.2.3., 10.2.2.4., 10.4.2.3, 10.4.2.4 of these Insurance Conditions) to a permanent place of residence, when it is allowed for medical reasons, within the terms and conditions determined by the Insurer or the Service Company, continuation of treatment in the insurance territory and/or independent return of the Insured Person's to the place of residence is carried out at the expense of the Policyholder (Insured Person) and is not reimbursed by the Insurer.

11. Non-reimbursable expenses according to the "Medical and other emergency expenses" risk.

According to the "Medical and other emergency expenses" risk, the following expenses are not reimbursed by the Insurer:

11.1. examinations and treatment of diseases (including chronic), injuries, poisoning and their consequences, complications, exacerbations, anomalies and malformations of organs that occurred before the start of the trip and require treatment or continuation of treatment during being on the insurance territory;

11.2. treatment, including in case of exacerbations and/or complications, of diseases such as tuberculosis, sarcoidosis, cystic fibrosis, chronic renal and hepatic insufficiency, hepatitis of any form, cirrhosis of the liver, diabetes mellitus and other endocrine diseases;

11.3. examination and treatment of systemic connective tissue diseases, Bekhterev's disease;

11.4. examination and treatment of blood diseases, herpes, mycosis (including candidiasis), parasitic diseases, polio, encephalitis, meningitis, polyneuritis;

11.5. treatment, including in case of exacerbations and/or complications, diseases, injuries of tissues, organs, limbs or their parts requiring their transplantation, implantation, reimplantation and/or prosthetics;

11.6. treatment, including in the event of exacerbations and/or complications, heart and vascular diseases of any localization requiring surgical or neurosurgical surgical treatment, including, but not limited to: coronary angiography, angiography, balloon angioplasty of coronary arteries, coronary artery bypass grafting, installation of stents and artificial valves, implantation of an electrocardiostimulator, installation of any permanent pacemakers, alloplasty, xenoplasty, bypass and vascular prosthetics, X-ray surgery on vessels and more), even if there are medical indications. If it is impossible to allocate the cost of surgical treatment specified in this paragraph from the total bill, its cost is assumed to be equal to 30% of the total amount of the bill for treatment and is excluded by the Insurer from the amount of the final bill for hospitalization.

11.7. arthroscopic treatment; expenses for osteosynthesis;

11.8. treatment of diseases of the nervous system (multiple sclerosis, speech disorders, etc.), musculoskeletal system, organs of vision and senses of non-traumatic genesis;

11.9. examination and treatment, including in the event of exacerbations and/or complications of mental illnesses, epilepsy, convulsive states, neuroses (depression, hysterical syndromes, stress), as well as various injuries resulting from exacerbations and/or complications of these diseases/conditions;

11.10. for consultations, examinations related to pregnancy and/or treatment of pregnancy complications regardless of the duration of pregnancy, as well as for prenatal and postpartum observation, childbirth (including premature or caesarean section). The Insurer does not bear any responsibility in relation to the newborn child and all expenses related to his/her treatment, being under medical supervision and movement are carried out at the expense of the Policyholder (Insured Person);

11.11. treatment of sexually transmitted diseases, as well as for the treatment of diseases that are their consequence or complication;

11.12. treatment of HIV infection and diseases that are its consequence or complication;

11.13. treatment of oncological diseases, neoplasms (malignant and benign), including hematopoietic and lymphatic tissue, as well as diseases that are their consequence or complication;

11.14. for the treatment of alcoholism, drug addiction and other abuses/addictions or other conditions associated with addiction or with the treatment of painful conditions, poisoning, exacerbations of chronic diseases caused by the intake of narcotic, toxic substances, alcoholic beverages, as well as for the treatment of injuries sustained by the Insured person who is in the above conditions when receiving an injury;

11.15. treatment of diseases, injuries received by the Insured Person as a result of his/her service in any armed forces or formations;

11.16. treatment of particularly dangerous infectious and tropical diseases such as plague, cholera, smallpox, yellow fever, hemorrhagic fevers, Dengue fever, anthrax, typhus, meningococcal infection, botulism, tularemia, Ebola, etc., with the exception of diphtheria and coronavirus infection;

11.17. treatment of injuries sustained during aquathlon, bungee jumping, base jumping, street acrobatics, roofing, rope jumping, parasailing, parkour, descents on prohibited routes, climbing buildings, jumping from high-rise buildings with a parachute or in special equipment;

11.18. treatment of diseases that are causally related to disability of group I, II, established by the insured person before the conclusion of the Insurance Contract;

11.19. treatment of chronic and recurrent diseases, their exacerbations and complications.

If an exacerbation or complication of a chronic disease causes a condition that threatens the life of the Insured Person, the limit of insurance compensation/expenses reimbursed by the Insurer is:

1) Under insurance programs A, MULTI, MULTI-1:

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 1,000 conventional units for each insured event;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 1,000 conventional units for each insured event;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 15,000 rubles for each insured event.

2) According to the insurance program B and MULTI–2:

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the country of citizenship – up to 2,000 conventional units for each insured event;

- when traveling on the territory of the Russian Federation of foreign citizens – up to 2,000 conventional units for each insured event;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation - up to 20,000 rubles for each insured event.

11.20. treatment of diseases included in the block "Excessive, frequent and irregular menstruation, other bleeding from the uterus and vagina, menstrual cycle disorders and in the menopausal period No. 92" of ICD 10, menstrual cycle disorders;

11.21. any transportation to the place of permanent residence, including with the necessary medical support, and repatriation of the body in connection with diseases/injuries and conditions specified in clauses 11.1. - 11.20 of the Insurance Conditions;

11.22. any transportation to the place of permanent residence, including with the necessary medical support, and/or repatriation of the body, not organized by the Insurer or the Service Company with which the Insurer cooperates, as well as expenses (including expenses for treatment, accommodation, meals, return to the place of permanent residence, etc.) incurred during refusal of the Insured Person or if such transportation has become impossible due to the actions or inaction of the Insured Person;

11.23. medical transportation to the place of permanent residence in case of minor illnesses or injuries that, for medical reasons, are amenable to local treatment and do not prevent the continuation of the Insured Person's trip or independent return to the place of permanent residence;

11.24. caused by professional errors/negligence of medical personnel;

11.25. related to contraception, sterilization, vasectomy (or reverse procedure), infertility treatment, fertilization or other forms of artificial reproduction, sex change or other sexual conditions;

11.26. extracorporeal methods of treatment (hemodialysis, plasmophoresis, etc.), UVI of blood;

11.27. methods of instrumental maintenance of body functions (ALV, etc.) in the amount of:

- exceeding 3,000 conventional units - when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the place of permanent residence;

- exceeding 3,000 conventional units - when traveling on the territory of the Russian Federation of foreign citizens;

- exceeding 20,000 rubles - when traveling on the territory of the Russian Federation citizens of the Russian Federation.

11.28. computed tomography, magnetic resonance imaging, magnetic nuclear tomography, not agreed with the Insurer and/or the Service Company with which the Insurer cooperates;

11.29. consultations with a general practitioner or a specialist and diagnostic examinations, as a result of which no sudden acute illness was detected, including the consequences of injury, poisoning, control examinations;

11.30. examination and treatment of hearing loss, removal of earwax blockage;

11.31. elimination of cosmetic defects of the face (including dental), body, limbs, regardless of the time of their occurrence;

11.32. cosmetic, plastic and reconstructive surgery and various types of prosthetics, including dental and eye prosthetics;

11.33. immune system correction, extended immunological examination;

11.34. abortions, spontaneous abortions;

11.35. treatment of periodontal diseases, replacement of old fillings, dental prosthetics, including preparation for it, restoration (reconstruction) of the crown part of the tooth, dental implantation, orthodontics;

11.36. treatment and care of the Insured person carried out by the relatives of the Insured person, regardless of whether they are professional medical workers or not;

11.37. health and rehabilitation treatment in hospitals (including day care), dispensaries, sanatoriums, boarding houses, hospitals, rest homes, rehabilitation centers and other organizations of medical and sanatorium-resort type;

11.38. physiotherapy, any type of massage, manual therapy, exercise equipment, physical therapy, swimming pool, hydrotherapy, heliotherapy, solarium, laser therapy, reflexotherapy (acupuncture and dry needling), hirudotherapy, chiropractic, homeopathy, phyto- and nature therapy, and other treatment using non-traditional methods of treatment and methods, officially not recognized by science and medicine;

11.39. hyperbaric oxygenation, except if extreme recreation and/or underwater sports are indicated in the "Additional conditions" column of the Insurance Policy;

If the Insurance Policy specifies extreme recreation and/or diving in the Additional Conditions column, the costs of hyperbaric oxygenation will be reimbursed only within 5,000 units for the entire period during the validity of the Insurance Contract, but subject to the exceptions specified in clause 11.73. of these Conditions.

11.40. general medical examinations, checkups for preventive purposes, for vaccination, disinfection, as well as for the purchase of medicines for preventive purposes;

11.41. purchase and repair of medical equipment; consumables for surgery (prostheses, orthopedic devices, metal structures, any other devices and tools), for the purchase of glasses, contact lenses, hearing aids, crutches, canes, splints, corsets, structurally complex bandages, as well as other corrective medical devices and tools and the cost of fitting them;

11.42. services related to the provision of additional comfort, namely: single rooms and suites, TV, telephone, air conditioner, humidifier, hairdresser, massage therapist, cosmetologist, translator (except for Insurance Program B) and so on;

11.43. surgical intervention or treatment, which may be postponed until the Insured returns to the place of permanent residence;

11.44. relief of pain syndrome with the use of an epidural blockade in an amount exceeding:

- 350 conventional units - when traveling outside the Russian Federation of Russian citizens and foreign citizens traveling outside the place of permanent residence;

- 350 conventional units - when traveling on the territory of the Russian Federation of foreign citizens;

- 20,000 rubles - when traveling on the territory of the Russian Federation citizens of the Russian Federation;

11.45. treatment of gout and metabolic syndrome;

11.46. diagnosis and treatment of strabismus, dry eye syndrome, visual acuity disorders, astigmatism, glaucoma, cataracts, dystrophic eye diseases;

11.47. removal of metal structures after the provision of specialized assistance in case of injury, including provided during the term of the Insurance Contract;

11.48. introduction of liquid medicinal structures into the joint that have the functions of prosthetics of tissues and fluids;

11.49. directly related to epidemics, environmental pollution, natural disasters or the introduction of quarantine in the insurance territory, known before the start of the planned trip;

11.50. arising as a result of the refusal of the Insured person to comply with the prescriptions of the attending physician or an expert doctor of the Service Company with which the Insurer cooperates, received by him/her in connection with an appeal regarding an insured event;

11.51. arising as a result of the fact that a trip to the insurance territory and/or engaging in active rest (summer, winter, extreme), certain sports, certain professional activities were contraindicated to the Insured Person for health reasons;

11.52. examinations and treatment, if the trip was undertaken by the Insured Person with the intention of receiving treatment;

11.53. related to the provision of services by a medical institution that does not have the appropriate license, or by a person who does not have the right to carry out medical activities;

11.54. related to the planned hospitalization of the Insured Person for treatment, even if this treatment is related to an insured event that has occurred, as well as caused by any complications that have arisen as a result of this treatment;

11.55. examination and treatment after the return of the Insured person to the place of permanent residence;

11.56. arising in connection with the deterioration of the health condition or death of the Insured person when the Insured Person makes a trip, despite the presence of direct medical contraindications;

11.57. in connection with an accident that occurred to the Insured Person as a result of a traffic accident, including when using a car, bicycle, motorcycle, moped, scooter, jet ski and ATV, all-terrain vehicle, snowmobile, boat, motor boat, etc., if:

a) the Insured person was driving a vehicle, not having the appropriate driver's license, and/or was in a state of

alcoholic, toxic or narcotic intoxication of any severity or under the influence of medications contraindicated when driving vehicles;

б) The insured person has transferred control of the vehicle to a person who does not have the appropriate driver's license and/or is in a state of alcoholic, toxic or narcotic intoxication of any severity or under the influence of medications contraindicated when driving vehicles;

в) The insured person was in the vehicle as a passenger, which was operated by a person who was in a state of alcoholic, toxic or narcotic intoxication of any severity or under the influence of medications contraindicated when driving vehicles, except for public transport and taxis;

г) The insured person neglected and did not use the security (protection) means both together and separately, such as: seat belt, helmet, life jacket, as well as other safety means provided for by the rules of operation of the vehicle;

11.58. incurred in connection with the health damage of the Insured person as a result of taking medicines without a doctor's appointment or on the doctor's prescription, but in violation of the dosage indicated by the doctor;

11.59. related to the provision of medical and other services that are not urgent and/or medically necessary;

11.60. examinations and treatment not prescribed by the attending physician;

11.61. examinations, tests, as well as for medical and other services performed/rendered at the request of the Insured Person contrary to the recommendations of the expert doctor of the Service Company and/or the Insurer;

11.62. study of insects and animals for the presence of infections;

11.63. treatment of sunburn and other diseases of the skin and subcutaneous fat, allergic reactions, if the insurance policy specifies the MULTI insurance program;

11.64. treatment of any manifestations and complications of diseases of the oral mucosa, fungal and skin diseases (psoriasis, dermatitis (including allergic and food), ingrown toenail, calluses, neurodermatitis, eczema, mycoses, papillomas, verruca and nevi, condyloma, acne, acneiform rash, blepharitis, allergic conjunctivitis, atheroma, alopecia, stomatitis), excluding infectious and viral diseases;

11.65. arising in connection with summer active rest, if the insurance policy does not specify "Active rest" in the "Additional risks" section. In any case, the expenses caused by the Insured's participation in competitions, races, horse races and other types of sports are not reimbursed;

11.66. arising in connection with winter active recreation, if the insurance policy does not specify "Winter active rest" in the "Additional risks" section. In any case, the expenses caused by the Insured's participation in competitions, races, horse races and other types of sports are not reimbursed;

11.67. arising in connection with extreme recreation activities, if the insurance policy does not specify "Extreme rest" in the "Additional risks" section. In any case, the expenses caused by the Insured's participation in competitions, races, horse races and other types of sports are not reimbursed;

11.68. arising in connection with professional and amateur sports, including during the Insured Person's participation in sports competitions, tournaments, training camps, if the insurance Policy does not specify a specific type of sport in the “Additional risks” section (in this case, the insurance will cover only the injury resulting from the additional risk directly specified in the insurance Policy);

11.69. arising in connection with the performance of official, labor activity by the Insured person (including employment), if a specific profession is not specified in the insurance Policy in the “Additional risks” section.

11.70. arising during the Insured's stay in a children's sports or health camp, if the insurance Policy does not specify "Children's sports camp" in the "Additional risks" section.

11.71. provision of any assistance included in the insurance program, in case the Insured Person refuses to arrange for his transfer to another medical institution offered by the Service Company;

11.72. related to the boarding of a scheduled or charter flight of an aircraft for medical reasons, in case of deterioration of the health of the Insured person on board;

11.73. provision of any assistance included in the insurance program for deep-sea diving with compressed air to a depth of more than 40 m, when diving to any depth using gas mixtures in which the oxygen content differs from 21 (twenty-one) percent, without a certificate of the scuba divers association, as well as when diving in over-the-head environments;

11.74. treatment of diseases that could have been prevented by early vaccination and/or resulting from the violation of preventive quarantine measures by the Insured Person;

12. Obligations of the Insured person upon the occurrence of an event that has signs of an insured event for the "Medical and other emergency expenses" risk

12.1. Upon the occurrence of an event that has the signs of an insured event, the Policyholder (Insured person) is obliged to:

12.1.1 before contacting a doctor, contact the Service Company (and if it is impossible to contact the Service Company - contact the Insurer) by the round–the-clock phone number specified in the Insurance Contract and inform:

- name and surname of the Insured person; his/her location and telephone number for communication;
- number of the Insurance Contract (Insurance Policy), name of the Insurer;
- reason for the request and the type of assistance required;
- other information requested by the representative of the Service Company or the Insurer.

Untimely notification of the Insurer about the occurrence of an event that has signs of an insured event gives the latter the right to refuse payment of insurance compensation, unless it is proved that the Insurer learned about the occurrence of the event in a timely manner, or that the absence of information from the Insurer about this could not affect its obligation to pay insurance compensation.

If, for a valid reason, the Insured Person cannot contact the Service Company (or the Insurer), it is necessary to contact the nearest medical institution or call an ambulance and contact the Service Company as soon as possible to receive instructions and guarantees of payment for the medical services provided. The occurrence of an insured event shall be reported to the Service Company (or the Insurer) before the end of the trip.

The **valid reason** for not contacting the Service Company (or the Insurer) under these Insurance Conditions means:

а) absence of telephone (fixed or mobile) communication at the location of the Insured person;

б) serious painful condition of the Insured person, which does not allow him/her to conduct telephone conversations;

12.1.2. be available to communicate with the Service Company's round-the-clock center using possible communication methods;

12.1.3. provide the Insurer and/or its representative (Service company, medical institution, etc.), upon their request, with written permission to receive information from medical and other institutions and assist in obtaining them;

12.1.4. at the request of the Insurer and/or his/her representative, provide copies of all pages of the passport with the appropriate marks of the border control service on crossing the border at entry/exit, the document that is the basis for staying in the insurance territory (visa of the country of the stay, migration card, temporary registration, etc.), medical treatment documents, travel documents, certificates of competent authorities, written explanations;

12.1.5. consent to conduct a test for alcohol narcotic/toxic/psychotropic drugs in a medical facility on the insurance territory at the request of the Insurer (refusal of the Insured to conduct the test gives the Insurer the right to refuse payment of insurance compensation);

12.1.6. follow the instructions received from the Service Company, provide it with the necessary information to provide the services provided for in the Insurance Contract;

12.1.7. observe the prescriptions of the attending physician, the schedule established by the medical institution in which the Insured person is undergoing treatment.

If, in violation of the prescriptions of the attending physician and/or the regulations established by the medical institution, there has been a deterioration in the health of the Insured person requiring additional treatment, then such additional treatment is carried out at the expense of the Insured Person and is not reimbursed by the Insurer.

12.1.8. give consent for transportation to the country of permanent residence (clause 10.1.2.3., 10.1.2.4., 10.2.2.3.,10.2.2.4., 10.4.2.3, 10.4.2.4 of these Insurance Conditions), if, according to the conclusion of the attending physician and the Service Company about the state of his/her health, such transportation of the Insured Person is possible.

In case of refusal of the Insured person from transportation provided for by the clauses 10.1.2.3, 10.1.2.4, 10.2.2.3., 10.2.2.4., 10.4.2.3, 10.4.2.4 of these Insurance Conditions, further stay in a medical institution and/or return of the Insured person to a permanent place of residence, is carried out at the expense of the Insured Person and is not reimbursed by the Insurer.

12.1.9. at the request of the Insurer, the Insured Person is obliged to undergo a medical check-up/examination appointed by the Insurer. In case of refusal to undergo an examination, the Insurer has the right to refuse payment of insurance compensation;

12.1.10. to receive insurance compensation, provide the Insurer with all the documents specified in clauses 13.6, 13.7 of these Insurance Conditions.

13. Procedure for payment of insurance compensation for the "Medical and other emergency expenses" risk

13.1. The Insurance payment is made by the Insurer by:

13.1.1 payment by the Insurer of the bills of the Service Company for the services provided by the Insurance Contract provided to the Insured Person upon the occurrence of an insured event, in the manner and on the terms stipulated by the conditions of the contract between the Insurer and the Service Company;

13.1.2. payment of the bills of the organization that provided the Insured person with the services provided by the Insurance Contract upon the occurrence of an insured event, in the time and manner agreed with the recipient organization;

13.1.3. reimbursement of the expenses incurred by the Insured Person for the insured event, provided that they comply with the obligations specified in the Insurance Contract. The Insured Person is responsible for proving the occurrence of the insured event and documenting the expenses incurred.

13.2. The deadline for the Insured Person to submit a written application and provide original documents to the Insurer to receive insurance compensation is 30 days from the date of return from the trip. If the Insurance Contract (Insurance Policy) provides for multiple trips, then return from the trip during which the insured event occurred is implied.

13.3. The decision on the insurance payment is made by the Insurer within 20 (twenty) working days from the date of receipt of all necessary documents provided for in these Insurance Conditions, confirming the occurrence of the insured event and the amount of expenses incurred.

13.4. In the presence of circumstances requiring special investigation, examinations and inspections, as well as obtaining additional information from medical institutions, judicial and other competent authorities, the decision on payment of insurance compensation may be suspended until the end of the investigation and/or receipt of the specified information, about which the Insurer sends the applicant a notification.

13.5. The insurance payment is determined in the amount of direct real expenses (losses) to be reimbursed under the Insurance Contract, but not more than the insured amount and the limits of compensation established in the Insurance Contract (Insurance Policy) for this type of insurance risk and/or expenses.

13.6. If the Insured Person has independently paid the costs agreed with the Service Company and/or the Insurer in connection with the insured event, the following documents shall be submitted to the Insurer in order to receive insurance compensation:

13.6.1. application for insurance payment;

13.6.2. Insurance Contract or its photocopy;

13.6.3. originals of documents from a medical institution (on letterhead or with an appropriate stamp) indicating the name and details of the medical institution or the surname and contact information of the doctor, the surname and name of the patient, diagnosis, date of seeking medical help, duration of treatment, with a list of services provided, broken down by dates and cost, with the total amount to payment;

13.6.4. originals of prescriptions issued by the doctor with the stamp of the pharmacy and a cash receipt confirming payment for medicines indicating the cost of each purchased medicine. Expenses for the purchase of medicines are reimbursed only if these medicines were prescribed by a doctor with an established diagnosis that is not included in the list of exceptions under the Insurance Contract;

13.6.5. the original of the referral issued by the doctor for laboratory tests and the bill from laboratory, broken down by dates, names and cost of services rendered, indicating the patient's name and surname, payment documents for the payment of these services;

13.6.6. official documents from the competent authorities (certificates of law enforcement and judicial authorities) confirming the fact of an accident (an act of occurrence of an accident) and the circumstances of the incident;

13.6.7. results of a test or examination for alcohol/narcotic/toxic/psychotropic substances in case of injury or accident;

13.6.8. in case of dental treatment – a document from a medical institution, which should indicate which teeth were treated and how exactly, as well as the cost of treatment and confirmation of the fact of payment;

13.6.9. originals of documents confirming the fact of payment for medical services, medicines (invoice with a payment stamp, bank confirmation of the transfer of the amount or cash receipt);

13.6.10. documents confirming the fact of payment of the Insured Person's transportation expenses (indicating the date, route, cost), as well as documents from the medical institution to which the Insured Person was delivered, indicating the name and surname of the Insured person, the date of treatment, diagnosis;

13.6.11. documents confirming the exchange/issuance of travel documents;

13.6.12. passport of the Insured person with marks of crossing the border of the permanent place of residence, to confirm the presence of the Insured person in the insurance territory during the occurrence of the insured event;

13.6.13. passport of a citizen of the Russian Federation of the Insured person or the country of citizenship of the Insured person;

13.6.14. at the request of the Insurer - information/documents on the state of health (discharge epicrisis for inpatient treatment and an extract from the patient medical record, an information letter from the TCMIF (territorial compulsory medical insurance fund) / Insurance organization that the Insured person has chosen for compulsory medical insurance, on the treatment for the last three years, the conclusion of a doctor, expert or medical commission;

13.6.15. The Insured Person is obliged to attach a translation into Russian prepared by a specialized organization engaged in the translation of documents to documents drawn up in a foreign language. By agreement of the parties, the translation can be made by the Insurer, while the Insurer has the right to deduct the costs of translating into Russian the documents submitted in connection with the insured event from the amount of the insurance payment.

13.6.16. details of the current account of the Policyholder (Insured person).

13.7. If the information contained in the documents provided by the Insured Person is not sufficient for the Insurer to make a decision on recognizing or not recognizing the event as an insured event and/or determining the amount of damage, the Insurer has the right to extend the time for reviewing documents for making a decision and in writing request additional documents from the Insured Person, Service Company, medical institutions and/or competent authorities (or copies thereof), as well as the right to conduct an independent investigation

13.8. The Insurer or the Service Company reserves the right to check the appropriateness of the expenses incurred by the Insured Person independently, with an appropriate adjustment of the amount of the insurance benefit.

13.9. After receiving all the necessary documents and information (clauses 13.6, 13.7 of these Insurance Conditions), the Insurer:

13.9.1. within 20 working days, recognizes the event as an insured event, draws up and approves an insurance act, which specifies the amount and procedure for making insurance payments, or decides not to recognize the event as an insured event and refuse insurance payment.

13.9.2. within 10 working days from the moment the Insurer makes a decision to recognize the event as an insured event, they make an insurance payment. If the event is not recognized as an insured event, the Insurer within 3 working days sends the Policyholder (Insured Person) a written refusal to pay, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the decision was made to refuse the insurance payment.

13.10. Insurance payments may not exceed the corresponding compensation limits established by these Conditions and the Insurance Contract.

13.11. Insurance payments made by paying the bills of the Service Company or the organization that provided the services are made in compliance with the current currency legislation of the Russian Federation and the terms of the contract concluded between the Insurer and the Service Company.

13.12. The insurance payment made directly to the Insured Person is made in rubles at the exchange rate of the Central Bank of the Russian Federation established for the corresponding foreign currency on the date of occurrence of the insured event.

The insurance payment is made by transferring the amounts to the bank account specified by the Insured Person or by other means agreed by the parties.

The date of withdrawal of funds from the Insurer's account is considered the payment day.

The costs of crediting to the account and receiving (debiting) from the recipient's account the amounts to be paid are carried out at the expense of the recipient's funds.

13.13. The insurer refuses the insurance payment in the presence of at least one of the following circumstances:

13.13.1. if the Insurance Contract is invalid in accordance with the legislation of the Russian Federation;

13.13.2. if expenses are reimbursed by third parties;

13.13.3. if the event occurred and the expenses incurred by the Insured Person are not reimbursable in accordance with paragraphs 3, 11 of these Insurance Conditions;

13.13.4. if the claimed event and expenses of the Insured Person did not actually take place or are not documented;

13.13.5. if the person who submitted the claim for insurance payment is not the Policyholder, Insured Person, Beneficiary or representative of any of these persons;

13.13.6. if any of the conditions provided for in clauses 12, 13.6, 13.7 of these Insurance Conditions are not met;

13.13.7. if the Insured Person refused to undergo a medical examination and/or checkup (inspection) appointed by the Insurer.

13.14. In case of non-fulfillment by the Insured Person (his/her representative) of the obligations stipulated in clause 12 of these Insurance Conditions, the Insurer has the right to refuse to further organize the settlement of an event that has signs of an insured event or to pay expenses in full or in part for the insured event, if non-fulfillment of obligations entails:

- impossibility of establishing the circumstances of the claimed event and/or unambiguous interpretation of the event as an insured event, confirmation or verification of the claimed information;

- loss of discounts in medical and transport institutions;

- additional expenses incurred due to late payment of bills;

- unjustified increase in the period of stay of the Insured person in the insurance territory;

- placement of warranty obligations for payment of expenses in the absence of sufficient information to recognize the case as insured.

13.15. If the case was recognized by the Insurer as an insured event and payments were made for it, but subsequently the specified case was recognized as non-insured due to the receipt of additional information not provided at the time of the decision to recognize the event that occurred with the Insured person as an insured event and on the insurance payment, the Insurer has the right to demand from the Insured or other beneficiary the refund of the paid insurance refunds.

SECTION III. THE "CANCELLATION OF THE TRIP" RISK

14. **An insured event for the "Cancellation of a trip" risk** are expenses (losses) of the Policyholder (Insured Person) due to the inability to carry out the planned trip for the following reasons, depending on the Insurance Program chosen by the Policyholder and specified in the insurance Policy:

14.1. Insurance Program A:

14.1.1. death of the Insured person or his/her close relatives: officially registered spouse, father, mother, children, including adopted children, adoptive parents, siblings, grandparents, grandchildren, official guardians and people under guardianship, as a result of sudden illness and/or injury, ascertained after the purchase of a tourist voucher by concluding an agreement on the sale of a tourist product, or after self-purchase of a ticket and/or payment for accommodation and other tourist services;

14.1.2. sudden acute illness and exacerbation of chronic illness of the Insured person requiring urgent hospitalization on the date of the start of the trip;

14.1.3. injury of the Insured person requiring urgent hospitalization on the date of the start of the trip and/or hindering the trip;

14.1.4. illness of the Insured person with special infantile infectious diseases (measles, rubella, chickenpox, scarlet fever, diphtheria, whooping cough, mumps), if on the date of the start of the trip the Insured Person is on inpatient treatment or is in isolation (quarantine);

14.1.5. refusal to issue an entry (transit) visa to the Insured person by the consulate (embassy) of a foreign state, while observing the following conditions:

- a full set of documents required for obtaining an entry (transit) visa was submitted to the consulate in accordance with the established procedure;
- the Insured person has no warnings about violations and direct violations of the rules of stay of Russian citizens in the territory of the foreign state to which a visa is requested;

14.2. Insurance Program B – for the reasons specified in Program A, as well as additionally:

14.2.1. hospitalization of close relatives of the Insured person: officially registered spouse, father, mother, children, including adopted children, adoptive parents, siblings, grandparents, grandchildren, official guardians and people under guardianship, as a result of a sudden illness requiring the presence of the Insured person;

14.2.2. destruction or damage to a residential premise belonging to the Insured person on the right of ownership, which occurred no earlier than 15 days before the start of the trip, as a result of fire, explosion, natural disasters, water damage from plumbing, sewage and heating systems, illegal actions of third parties, provided that the damage caused is significant and makes the residential premise unsuitable for living;

14.2.3. court proceedings occurring during the period of the Insured Person's trip, in which he/she participates by a court decision/ruling, if the court summons was received after the purchase of a tourist voucher, ticket and/or payment for accommodation, except for the following cases: participation of the Insured person in the court proceedings as a plaintiff, representative of the plaintiff or defendant, and/or if the Insured Person performs professional or labor functions;

14.2.4. calling the Insured person to perform military duties and other public duties during the planned trip, if the call (summons) is received after the purchase of a tourist voucher, ticket and/or payment for accommodation;

14.2.5. a traffic accident with a car in which the Insured person was traveling to the airport (train station, port) to travel to the insurance territory specified in the Insurance Contract for the "Medical and other emergency expenses" risk or for the "Accident" risk.

15. Upon the occurrence of an insured event for the "Cancellation of the trip" risk, the expenses actually incurred by the Policyholder (Insured Person) for the trip are reimbursed, minus the refund amounts made by the travel company (tour operator/travel agent), airline or other transport company, the organization through which the accommodation was paid, and the consular fee for the Insured Person paid when applying for a visa.

16. Non-reimbursable expenses for the "Cancellation of the trip" risk.

16.1. At the "Cancellation of the trip" risk, expenses related to the forced cancellation of the trip are not reimbursed if they occurred as a result of:

16.1.1. changes in travel dates at the initiative of the Policyholder/Insured person, tour operator/travel agent and/or carrier;

16.1.2. cancellation of the trip due to the fault of the tour operator/travel agent, carrier, including bankruptcy, liquidation of the tour operator/travel agent, carrier;

16.1.3. bringing the Insured Person to responsibility for violation of administrative, criminal, customs legislation of the Russian Federation;

16.1.4. violations by the Insured person of the visa rules and entry procedure adopted by the States of the trip destination;

16.1.5. the Insured Person has legal restrictions on exit/entry, which the Insured Person knew or should have known about;

16.1.6. non-fulfillment by the Insured person of obligations imposed by the court and transfer of cases for execution to the bailiff service;

16.1.7. validity period of the Insured Person's passport is less than 3 (three) months after the end date of the trip;

16.1.8. need for treatment, including in the event of exacerbations and/or complications of diseases such as tuberculosis, sarcoidosis, cystic fibrosis, chronic renal and hepatic insufficiency, hepatitis of any form, cirrhosis of the liver, diabetes mellitus and other endocrine diseases, systemic connective tissue diseases, ankylosing spondylitis, blood diseases, herpes, mycosis (including candidiasis), parasitic diseases, polio, encephalitis, meningitis, polyneuritis;

16.1.9. need to treat diseases of the nervous system (multiple sclerosis, speech disorders and others), musculoskeletal system, organs of vision and senses of non-traumatic genesis;

16.1.10. need for treatment, including in the event of exacerbations and/or complications of mental illnesses, epilepsy, convulsive states, neuroses (depression, hysterical syndromes, stress), as well as various injuries resulting from exacerbations and/or complications of these diseases/states;

16.1.11. state of pregnancy and/or the need for treatment of pregnancy complications regardless of the duration of pregnancy, as well as prenatal observation, childbirth (including premature or cesarean section);

16.1.12. need for the treatment of sexually transmitted diseases, as well as the treatment of diseases resulting from them;

16.1.13. need to treat HIV infection and diseases that are its consequence or complication;

16.1.14. need for examination and treatment of oncological diseases, neoplasms (malignant and benign), including hematopoietic and lymphatic tissue, as well as diseases that are their consequence or complication;

16.1.15. need for treatment for alcoholism, drug addiction and other abuses/addictions or other conditions associated with addiction or with the treatment of painful conditions caused by the intake of narcotic, toxic substances, alcohol, as well as the treatment of injuries sustained by the Insured person who is in the above conditions at the time of injury;

16.1.16. need for planned treatment and/or examination;

16.1.17. need to treat diseases, injuries received by the Insured Person as a result of his/her service in any armed forces or formations;

16.1.18. refusal/delay in issuing an entry visa for the following reasons:

- in the international passport of the Insured person provided to the consular office of a foreign state for obtaining a visa, there is a note on the refusal to issue a visa earlier (or a note on the acceptance of documents for consideration for a visa, but the visa was not affixed) by the embassies of any country;

- in the international passport of the Insured person provided to the consular office of a foreign state for obtaining a visa, there are marks of the border services about the violation of the visa regime when the Insured person visits any foreign state or marks about the deportation of the Insured person from any foreign state;

- the international passport of the Insured person, provided to the consular institution of a foreign state for obtaining a visa, is in poor condition or has damage and blots;

- the visa application documents were submitted in violation of the deadlines set by the authorized body of a foreign state for issuing a visa (s) or did not meet its requirements;

- the visa application documents were submitted to a representative office of a foreign state that is not authorized to issue visas to persons residing at the place of permanent registration of the Insured;

16.1.19. non-compliance with the requirements of consular services when applying for visas for a foreign trip;

16.1.20. preparation of documents for obtaining an entry visa by a legal entity that is not a tour operator for this tour (trip).

17. Conditions for payment of insurance compensation for the "Cancellation of the trip" risk.

17.1. The Insured person is obliged to inform the Insurer in writing about the occurrence of an event that has signs of an insured event. The nature and circumstances of the event shall be indicated in the application. The following documents shall be attached to the application:

17.1.1. original Insurance Contract (Insurance Policy);

17.1.2. original (notarized copy) of the agreement on the sale of a tourist product and documents confirming payment, issued in accordance with the Federal Law "On the Basics of Tourist Activity in the Russian Federation" No. 132-FZ dated 24.11.1996.

In case of self-organized trip: travel documents and documents confirming their payment, documents confirming payment for hotel accommodation;

17.1.3. in case of cancellation of a trip due to sudden illness, injury: discharge epicrisis from a medical institution (hospital), an extract from the patient medical record from a medical institution for the entire period of treatment, official documents from competent authorities (certificates of law enforcement and judicial authorities) confirming the fact of an accident, if the cause of the event is an accident; in case of childhood infections — a certificate about being quarantined for an infectious disease and an extract from the patient medical record from a medical institution for the entire period of treatment;

17.1.4. in case of refusal to obtain an entry visa: the official refusal of the consular service of the embassy (if one was issued) and the original passport with a stamp of refusal to issue a visa, or a notarized copy of the title page of the passport and the page on which the stamp of refusal to issue a visa is affixed;

17.1.5. if it is impossible to make a trip due to a court proceeding: a court-certified summons and/or a ruling, decision, resolution;

17.1.6. if it is impossible to make a trip as a result of destruction or damage to a residential premise: documents confirming the Insured person's ownership of the residential premise, documents (certified copies) from the competent authorities (Ministry of Emergency Situations, police) confirming the fact and circumstances of the damage;

17.1.7. in case of cancellation of the trip due to the delay of the Insured person on his/her way to the airport (train station, port) due to a road accident: protocol, resolution (definition) of the internal affairs bodies confirming the fact of the road accident;

17.1.8. documents confirming the return of funds by the tour operator/ travel agent in accordance with the provisions on the termination of the contract on the sale of a tourist product, the calculation of the refund and a copy of the expenditure order;

17.1.9. in case of conclusion of an agreement on the sale of a tourist product through a travel agent: an agency agreement between the travel agent and the tour operator and documents confirming the transfer of funds by the travel agent to the tour operator under this agreement on the sale of a tourist product;

17.1.10. financial documents of the tour operator/travel agent confirming the actual expenses incurred by the tour operator/travel agent in connection with the execution of the contract on the sale of a tourist product concluded with the Policyholder/ Insured person;

17.1.11. in case of a self-organized trip: documents from the transport company and the hotel confirming the expenses of the Policyholder/Insured person in connection with the cancellation of the trip;

17.1.12. at the request of the Insurer: information/documents on the state of health (discharge epicrisis for inpatient treatment and an extract from the patient medical record), an information letter from the territorial fund of compulsory medical insurance or the insurance organization that the Insured person has chosen for compulsory medical insurance, on the treatment for the last three years, the conclusion of a doctor, expert or medical commission;

17.1.13. details of the current account of the Policyholder (Insured person).

17.2. The Insured Person is obliged to attach a translation into Russian made by a specialized organization engaged in the translation of documents to documents drawn up in a foreign language. By agreement of the parties, the translation can be made by the Insurer, while the Insurer has the right to deduct the costs of translating into Russian the documents submitted in connection with the insured event from the amount of the insurance payment.

17.3. If the information contained in the documents provided by the Insured Person is not sufficient for the Insurer to make a decision on recognizing or not recognizing the event as an insured event and/or determining the amount of damage, the Insurer has the right to increase the time for reviewing documents for making a decision and request in

writing from the Insured person, tour operator/travel agent, transport companies, medical institutions and/or the competent authorities have additional documents (or copies thereof), as well as the right to conduct an independent investigation.

17.4. The Insurer reserves the right to verify the appropriateness of expenses incurred by the Insured Person independently, with appropriate adjustment of the amount of payment.

17.5. After receiving all the necessary documents and information (clauses 17.1-17.3 of these Insurance Conditions), the Insurer:

17.5.1. within 20 working days, recognizes the event as an insured event, draws up and approves an insurance act indicating the amount and procedure for making insurance payments, or decides not to recognize the event as an insured event and refuse the insurance payment;

17.5.2. within 10 working days from the moment the Insurer makes a decision to recognize the event as an insured event, they make an insurance payment. If the event is not recognized as an insured event, the Insurer within 3 working days sends the Policyholder (Insured Person) a written refusal to pay, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the decision was made to refuse the insurance payment.

17.6. The insurance payment for the "Cancellation of the trip" risk may not exceed the sum insured specified in the Insurance Contract for this risk.

17.7. The beneficiary of the "Cancellation of the trip" risk is the Policyholder (Insured person) who is the buyer (payer) of tourist services under the agreement on the sale of a tourist product or who paid for travel and accommodation during an independently organized trip.

17.8. The Insurer refuses the insurance payment in the presence of at least one of the following circumstances:

17.8.1. if the Insurance Contract is invalid in accordance with the Legislation of the Russian Federation;

17.8.2. if expenses are reimbursed by third parties;

17.8.3. if the event that has occurred and the expenses incurred by the Insured Person are exceptions specified in paragraphs 3, 16 of these Insurance Conditions;

17.8.4. if the claimed event and expenses of the Insured Person did not actually take place or are not documented;

17.8.5. if the person who submitted the claim for insurance payment is not the Policyholder, the Insured Person or a representative of any of these persons.

SECTION IV. THE "ACCIDENT" RISK INSURANCE

18. The insured events for the "Accident" risk include, depending on the Insurance Program chosen by the Policyholder and specified in the Insurance Policy, the following events that occurred during the term of the Insurance Contract in the insurance territory specified in the Insurance Contract (Insurance Policy):

18.1. Insurance program A

18.1.1. injury as a result of an accident (clause 1.3 of these Insurance Conditions);

18.1.2. death of the Insured person due to an accident.

18.2. Insurance Program B - events provided for by Insurance Program A, as well as additionally:

18.2.1. disability of group I, II, III or the category of "disabled child", initially established to the Insured person as a result of an accident. In this case, the disability of the Insured Person shall be established within a period not exceeding 12 months from the date of the occurrence of the event specified in this paragraph and which caused the disability.

19. Events resulting from the events listed in clause 3 of these Insurance Conditions, as well as events that took place before the start of the insurance period and after the end date of the insurance period, as well as events that occurred during the term of the Insurance Contract and on the insurance territory that occurred with the Insured Person, **are not recognized as insured events for the "Accident" risk**, under the following circumstances or as a result:

19.1. recognition by the court of the Insured person as missing or declaring him/her dead by the court;

19.2. injuries sustained during seizures with epilepsy;

19.3. injuries sustained during summer active rest, if the insurance Policy does not specify "Active rest" in the

"Additional risks" section. In any case, injuries sustained by the Insured in competitions, races, horse races and other types of sports are not an insured event;

19.4. injuries sustained during winter active rest, if the insurance policy does not specify "Winter active rest" in the "Additional risks" section. In any case, injuries sustained by the Insured in competitions, races, horse races and other types of sports are not an insured event;

19.5. injuries sustained during extreme rest, if the insurance policy does not specify "Extreme rest" in the "Additional risks" section. In any case, injuries sustained by the Insured in competitions, races, horse races and other types of sports are not an insured event;

19.6. injuries sustained during professional and amateur sports, including during the Insured Person's participation in sports competitions, tournaments, training camps, if the insurance Policy does not specify a specific type of sport in the “Additional risks” section (in this case, the insurance will cover only the injury resulting from the additional risk directly specified in the Insurance contract);

19.7. injuries sustained during the performance of official, labor or other activities by the Insured person (including work for hire) involving physical activity and capable, in the opinion of the Insurer, of increasing the risk of an insured event, if a specific profession is not specified in the Insurance Policy in the “Additional risks” section.

19.8. injuries sustained during the Insured's stay in a children's sports or health camp, if the insurance Policy does not specify "Children's sports Camp" in the "Additional risks" section.

20. Upon the occurrence of an event that has signs of an insured event, the Insured Person is obliged to:

20.1. immediately contact the Insurer by the phone number specified in the Insurance Contract (Insurance Policy) and inform:

- name and surname of the Insured person, his/her location and telephone number for communication;

- number of the Insurance Contract (Insurance Policy);

- reason for the request;

- other information that the Insurer will request.

20.2. be available for communication with the Insurer using possible communication methods;

20.3. provide the Insurer, upon request, with written permission to obtain information from medical and other institutions and assist in obtaining them;

20.4. consent to conduct a test for alcohol/narcotic/toxic/psychotropic drugs in a medical facility on the insurance territory the at the request of the Insurer;

20.5. at the request of the Insurer to undergo a medical examination (inspection) appointed by the Insurer. In case of refusal to undergo an examination (inspection), the Insurer has the right to refuse to pay the insurance indemnity.

20.6. To receive the insurance indemnity, provide the Insurer with all the documents specified in clauses 21.5-21.8 of these Insurance Conditions.

21. Conditions for payment of insurance compensation for the "Accident" risk.

21.1. Upon the occurrence of the events provided for in clause 18.1.1 of these Insurance Conditions, the amount of the insurance benefit is determined as a percentage of the insured amount in accordance with the "Table of insurance benefits for the "Accident" risk (Appendix No. 2 to these Insurance Conditions).

21.2. When the disability group (category) is established for the Insured person (clause 18.2.1 of the Insurance Conditions), the insurance benefit is determined in the following amounts from the insured amount:

- 100% when establishing the I disability group;

- 70 % when establishing the II disability group;

- 40 % when establishing the III disability group;

- 30% when establishing the "disabled child" category.

21.3. In connection with the death of the Insured Person (clause 18.1.2 of the Insurance Conditions), the amount of the insurance benefit is 100% of the insured amount minus the payments provided for in clauses 21.1 and 21.2 of these Insurance Conditions, if they were made or should be made according to previously provided documents.

21.4. The total amount of insurance payments for the "Accident" risk may not exceed the amount of the insured amount established for the Insured Person for this risk.

21.5. Upon the occurrence of an event that has the signs of an insured event, the Insured Person, and in the event of his/her death - the Beneficiary, if they are not appointed, the heir (s) of the Insured Person, is obliged to provide the Insurer with the following documents:

- written application for payment in the form established by the Insurer, indicating reliable information about the circumstances in which the claimed the event, as well as bank details for transferring the insurance payment;

- identity document of the applicant;

- original Insurance Contract (Insurance Policy);

- medical documents confirming the fact of an accident with the Insured person during the period of validity of the Insurance Contract, the circumstances of the occurrence of the accident, the full diagnosis, the duration of treatment, therapeutic and diagnostic measures;

- primary radiographs, if the injury was accompanied by bone injuries (dislocations, subluxations, epiphyseolysis, fractures, separation of bone fragments);

- documents from the competent authorities on the investigation of the circumstances of the accident. These documents shall contain information about the facts of the occurrence of an insured event with the Insured person and the nature of the damage received by him/her;

- results of a test or examination for alcohol/narcotic/toxic/psychotropic substances;

- act on an industrial accident or a similar document drawn up in the host country is submitted, if necessary, when the connection of the claimed case with the performance of official duties by the Insured shall be established;

- notarized copy of the certificate of the medical and social expertise authority (MSEA) on the establishment of the disability group to the Insured person - submitted in case of disability;

- conclusion (extract from the certificate of examination) of the Bureau of medical and social expertise on the results of the examination and the establishment of a disability group;

- notarized copy of the Death Certificate of the Insured person – submitted in case of death;

- medical document (or a copy of it certified in accordance with the procedure established by the legislation of the Russian Federation) indicating the cause of death of the Insured person (a copy of the medical Death Certificate of the Insured person, etc.) – submitted in case of death;

- copy of the protocol of the medicolegal autopsy of the Insured person (if necessary, if the autopsy was performed);

- Certificate of the right to inheritance or its notarized copy - submitted only by the heir or heirs of the Insured person.

All submitted documents from medical institutions or competent organizations shall be submitted on the appropriate form and certified with a signature and an appropriate seal, if the document is not drawn up on a form, the stamp of the institution that issued the document is mandatory;

-details of the current account of the Policyholder (Insured person)/Beneficiary;

21.6. At the request of the Insurer, the Insured Person is obliged to provide information/documents on the state of health: a discharge epicrisis for inpatient treatment and an extract from the patient medical record, an information letter from the territorial compulsory medical insurance fund/insurance company that the Insured person has chosen for compulsory medical insurance for the last three years, the conclusion of a doctor, expert or medical commission.

21.7. The Insured Person (Beneficiary) is obliged to attach a translation into Russian prepared by a specialized organization engaged in the translation of documents to documents drawn up in a foreign language. By agreement of the parties, the translation can be made by the Insurer, while the Insurer has the right to deduct the costs of translating into Russian the documents submitted in connection with the insured event from the amount of the insurance payment.

21.8. If the information contained in the documents provided by the Insured Person is not sufficient for the Insurer

to make a decision on recognizing or not recognizing the event as an insured event and/or determining the amount of damage, the Insurer has the right to extend the time for reviewing documents for making a decision and in writing request additional documents from the Insured Person, Service Company, medical institutions and/or competent authorities (or copies thereof), and also has the right to conduct an independent investigation.

21.9. The Insurer reserves the right to verify the circumstances of the occurrence of an insured event.

21.10. After receiving all the necessary documents and information (clauses 21.5. - 21.8. of these Insurance Conditions), the Insurer:

- within 20 working days recognizes the event as an insured event, draws up and approves an insurance act indicating the amount and procedure for making insurance payments, or decides not to recognize the event as an insurance event and refuse insurance payment.

- within 10 working days from the moment the Insurer makes a decision to recognize the event as an insured event, makes an insurance payment. In case of non-recognition of the event as an insured event, the Insurer within 3 working days sends to the Policyholder (Insured person)/Beneficiary a written refusal to pay, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the decision was made to refuse the insurance payment.

21.11. Insurance payments for the "Accident" risk may not exceed the compensation limits set out in paragraphs 21.1 -21.3 of these Conditions, and the total amount of compensation for the period of validity of the Insurance Contract may not exceed the insurance amount established in the Insurance Contract for this risk for each Insured Person.

21.12. The insurance payment may be made:

21.12.1. To the Insured person;

21.12.2. To the beneficiary specified in the contract;

21.12.3. To the heirs of the Insured Person in the event of:

- if the Insured died without receiving the insurance payment due to him/her;

- if the Beneficiary intentionally took the life of the Insured Person or intentionally caused him/her bodily injuries that caused his/her death;

- if the Beneficiary was not appointed or died earlier than the Insured Person;

- if the death of the Insured Person and the Beneficiary occurred before the decision on the insurance payment was made;

21.12.4. to the Beneficiary's heirs, if the death of the Insured person was followed by the death of the Beneficiary, and he/she did not have time to receive the insurance payment due to him/her.

21.13. The insurance payment is made in rubles by transferring the amounts to the bank account specified by the Insured Person (Beneficiary, Heir), or otherwise by agreement of the parties.

21.14. The Insurer refuses the insurance payment in the presence of at least one of the following circumstances:

21.14.1. if the Insurance Contract is invalid in accordance with the Legislation of the Russian Federation;

21.14.2. if the damage is compensated by third parties;

21.14.3. if the event that has occurred is not recognized as an insured event in accordance with the conditions of the Insurance Contract;

21.14.4. if the claimed event did not take place or is not documented;

21.14.5. if the person who submitted the claim for insurance payment is not the Policyholder, Insured Person, Beneficiary or Heir;

21.14.6. if the event that has occurred is a consequence of the events listed in paragraphs 3, 19 of these Insurance Conditions;

21.14.7. if any of the conditions stipulated in clauses 20, 21.5-21.8 of these Insurance Conditions are not met.

SECTION V. THE "LOSS OF BAGGAGE" RISK

22. The insured event for the risk of "Loss of baggage", depending on the Insurance Program chosen by the Policyholder and specified in the insurance Policy, are the following events:

22.1. Insurance program A:

22.1.1. loss (missing) of baggage officially transferred to the carrier when the Insured Person travels from the place of permanent residence to the insurance territory and back, as well as when the Insured Person moves between countries and regions included in the insurance territory.

22.1.2. occurrence of necessary and urgent expenses of the Insured Person due to the delay of baggage for a period of more than 3 hours for the purchase of essential goods in the amount of:

- no more than 100 conventional units (limit of liability) when traveling outside the Russian Federation of Russian citizens and foreign citizens.

- no more than 5,000 rubles (liability limit) when traveling on the territory of the Russian Federation of Russian citizens and foreign citizens.

24. Non-reimbursable expenses for the "Loss of baggage" risk

24.1. Insurance for the "Loss of baggage" risk does not apply to:

24.1.1. loss of baggage traveling with the Insured Person as hand luggage, as well as baggage transferred to the carrier without registration or in violation of the registration procedure;

24.1.2. loss of baggage containing explosive, poisonous and/or caustic substances;

24.1.3. non-fulfillment or improper fulfillment by the Insured Person of his/her obligations related to the transportation and storage of baggage, including payment, packaging conditions and timely receipt of baggage;

24.1.4. sports equipment during its transportation;

24.1.5. loss due to confiscation of baggage by authorized bodies;

24.1.6. cases of loss of baggage that were not reported/declared in accordance with the procedure provided for by law and these Conditions to the carrier.

25. Conditions for payment of insurance compensation for the "Loss of baggage" risk.

25.1. Upon the occurrence of an event that has the signs of an insured event, the Policyholder (Insured person) is obliged to:

25.1.1. Immediately report the incident to the competent authorities at the place of stay (police, customs, etc.) and the administration of the institution at the place of stay (hotel, airport, train station, etc.).

25.1.2. Ensure that a document recording the fact of loss (act, protocol) is drawn up at the scene of the incident and take measures to preserve the remaining baggage. The refusal of the competent authorities to draw up proper documents shall also be made in writing.

25.1.3. Submit a claim to the person responsible for the losses.

25.1.4. Immediately, but in any case, no later than 3 days (except weekends and holidays) after returning to a permanent place of residence, notify the Insurer or their representative thereof in the manner specified in the insurance policy.

25.2. Failure to comply with the requirements of clause 25.1 of these Conditions may serve as a basis for refusal of insurance payment or for reduction the amount of insurance compensation in terms of losses not documented.

25.3. If the information contained in the documents provided by the Policyholder (Insured Person) is not sufficient for the Insurer to make a decision on the recognition or non-recognition of the event as an insured event and/or determining the amount of damage, the Insurer has the right to extend the terms of consideration of documents for decision-making and in writing request additional documents from the Policyholder (Insured Person) and other institutions (or copies thereof), as well as the right to conduct an independent investigation.

25.4. The Policyholder (Insured person) is obliged, within 30 (thirty) calendar days from the date of return from a trip during which an incident occurred that has signs of an insured event, to submit to the Insurer an application for payment in the form established by the Insurer with the attachment of the originals of the following documents:

- Insurance Contract (Insurance Policy);

- a foreign passport of the Insured person with marks of crossing the border of the permanent place of residence, to confirm the presence of the Insured person in the insurance territory during the occurrence of the insured event;

- internal passport – for citizens of the Russian Federation;

- details of the current account of the Policyholder (Insured person);

- originals of documents confirming the transfer of baggage to the carrier (baggage receipt, receipt for storage, etc.);

- originals of documents previously submitted to the Insurer and/or the Service Company in the form of copies or by fax or electronic communication;

- written explanations of the circumstances and other documents necessary to confirm the fact of the insured event and the amount of losses incurred (damage caused);

- original ticket (boarding pass);

- a copy of the claim and other documents required to submit a claim to the carrier filed within the time limit contained in the carrier's conditions of carriage; a copy of the carrier's response to the claim;

- a document confirming the delay of the flight and/or baggage with the carrier's mark, including the flight number and the place where the delay occurred and the number of hours of delay;

- documents confirming the expenses for the purchase of the minimum necessary essentials, made directly in connection with the delay of baggage.

25.5. If the documents submitted by the Insured Person are drawn up in a foreign language, translations shall be attached to them, and in some cases, at the request of the Insurer, notarized translations.

25.6. After receiving all the necessary documents and information (clauses 25.4, 25.5 of these Conditions) The Insurer:

- within 20 working days (unless another period is specified in the Insurance Contract) recognizes the event as an insured event, draws up and approves an insurance act indicating the amount and procedure for making insurance payments, or decides not to recognize the event as an insured event and refuse insurance payment.

- within 10 working days from the moment the Insurer makes a decision to recognize the event as an insured event, makes an insurance payment. If the event is not recognized as an insured event, the Insurer within 3 working days sends the Policyholder (Insured Person) a written refusal to pay, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the decision was made to refuse the insurance payment.

25.7. The insurance payment is made in the following amount:

25.7.1. if the baggage is delayed for more than 3 hours:

- when traveling outside the Russian Federation of citizens of the Russian Federation and foreign citizens traveling outside the place of permanent residence - 5 conventional units for each hour of baggage delay over 3 hours, but not more than the limit of liability established in clause 22.1.2 of the Insurance Conditions, minus compensation paid or due to the Policyholder (Insured person) by the responsible carrier;

- when traveling on the territory of the Russian Federation of citizens of the Russian Federation or foreign citizens - 150 rubles for each hour of baggage delay over 3 hours, but not more than the limit of liability established in clause 22.1.2 of the Insurance Conditions, minus compensation paid or due to the Policyholder (Insured Person) by the responsible carrier;

25.7.2. in case of loss of baggage – in the amount of 1000 rubles for each kilogram of lost baggage, but not more than the limit of compensation (insurance amount) established in relation to the "Loss of baggage" risk, minus compensation paid or due to the Policyholder (Insured person) by the responsible carrier.

25.8. The Insurer refuses the insurance payment in the presence of at least one of the following circumstances:

25.8.1. if the Insurance Contract is invalid in accordance with the Legislation of the Russian Federation;

25.8.2. if the loss is compensated by third parties;

25.8.3. if the event that has occurred is not recognized as an insured event in accordance with the conditions of the Insurance Contract;

25.8.4. if the claimed event did not take place or was not documented;

25.8.5. if the event occurred and the expenses incurred by the Insured Person are exceptions specified in clause 24 of these Conditions;

25.8.6. if any of the conditions provided for in clauses 25.4, 25.5 of these Conditions are not met;

25.8.7. reasons and circumstances listed in clause 3 of these Conditions.

SECTION VI. THE "CIVIL LIABILITY" RISK

26. An insured event **for the "Civil Liability" risk**, depending on the Insurance Program chosen by the Policyholder and specified in the Insurance Policy, is an actual, sudden, unforeseen and unintended event, as a result of which the Insured is obliged, by virtue of a court decision that has entered into force, to compensate third parties for damage caused to the life, health or property of an individual or property of a legal entity.

27**. In accordance with the program A** under the "Civil Liability" risk, the following necessary and documented expenses related to the insured event are reimbursed:

27.1. direct real damage caused to a third party as a result of damage (destruction), loss of property belonging to a third party on the basis of property rights or on the basis of a legitimate documented legal relationship, within the actual value of the property or the cost of its restoration (repair);

27.2. real damage due to injury to the life and health of individuals determined by the laws of the country that is the insurance territory;

27.3. reasonable expenses for preliminary clarification of the circumstances of the occurrence of the insured event and the degree of guilt of the Insured person;

27.4. expenses for conducting cases in the judicial authorities in cases of damage caused by the Insured person to third parties.

28. Non-reimbursable expenses for the "Civil liability" risk

28.1. For the "Civil liability" risk the following is not reimbursed:

28.1.1. expenses caused by the occurrence of liability in the use and operation of any vehicles;

28.1.2. expenses in connection with the voluntary (pre-trial) recognition by the Insured person of the fact of the occurrence of his/her civil liability to third parties without prior agreement with the Insurer;

28.1.3. expenses caused by the commission by the Insured person of intentional actions or a crime that is in direct causal connection with the damage caused;

28.1.4. expenses in connection with the onset of civil liability of close relatives of the Insured person, including those who are not fully capable;

28.1.5. expenses due to liability of any kind arising directly or indirectly, or partially as a result of pollution by the Insured Person of the atmosphere, water or soil;

28.1.6. expenses caused by the onset of liability for infection with any diseases and viruses;

28.1.7. expenses caused by liability resulting from criminal prosecution under the laws of the country of temporary residence;

28.1.8. expenses on claims for damages related to infringement of copyrights, rights to discovery, invention, unauthorized use of registered business logos, trademarks and/or logotype, symbols, names;

28.1.9. expenses incurred as a result of the Insured Person's professional, labor activity under the agreement and/or contract;

28.1.10. any damage caused by persons for whom the Insured Person is legally responsible;

28.1.11. any damage caused by an animal owned by the Insured person.

29. Obligations of the parties upon the occurrence of an insured event

29.1. Upon the occurrence of events that may serve as a basis for claims against the Insured Person by third parties for compensation for damage caused by him/her, the Insured Person (his/her representative) and/or the Policyholder are obliged:

29.1.1. immediately, within no more than 24 hours from the date of the accusation, claim, etc., notify the Service Company and/or the Insurer of the incident in any available way that allows you to objectively record the fact of the message and follow all the instructions of the Service Company;

29.1.2. if the Insured Person has information about the upcoming prosecution, investigation, investigation, trial, he/she shall immediately notify the Insurer and/or the Service Company;

29.1.3. if the Insured Person is unable to contact the Service Company or the Insurer due to circumstances, he/she may instruct his/her representative to do so;

29.1.4. without the written consent of the Insurer or the Service Company, not to make any promises, either in writing or orally, and not to make proposals for voluntary compensation for the losses incurred, not to admit in whole or in part their guilt (liability), not to pay any amounts in compensation for damage, not to make promises of payment or to discuss the terms of any claim without the written consent of the Insurer.

30. If the Policyholder (Insured Person) fails to comply with the requirements of clause 29.1 of these Insurance Conditions, the Insurer has the right to refuse the insurance payment or reduce its amount.

31. When applying for assistance provided for in the Insurance Contract, the Insured Person (his/her representative) and/or the Policyholder is obliged to provide additional information:

31.1. about the nature of the damage caused to third parties;

31.2. about the actions taken by the participants involved in the settlement of the event and the authorities upon the fact of causing harm.

32. Upon receipt of a notification of the occurrence of events that have signs of an insured event, the Insurer decides on the expediency of carrying out any actions on its part and on the part of the Service Company aimed at protecting the interests of the Insured Person.

33. If necessary, the Insurer and/or the Service Company has the right to require the Insured Person or the Policyholder to provide written explanations and/or documents available to them. In this case, the Insured person (his/her representative) and/or the Policyholder is obliged to immediately forward the necessary documents in a way agreed with the Insurer (Service Company).

34. Upon receipt of any claims, demands, summonses, invitations to examinations and other documents from third parties and/or competent authorities related to the fact of damage, the Insured Person (his/her representative) and/or the Policyholder is obliged to immediately notify the Insurer and/or the Service Company within 24 (twenty-four) hours by the phone numbers specified in the Insurance Contract and forward the received documents by fax or electronic communication to the number and/or email address specified by the Insurer/Service Company.

35. When making a court decision in a case of harm to third parties, the Insured Person (his/her representative) and/or the Policyholder is obliged to immediately notify the Insurer and/or the Service Company about this within 24 (twenty-four) hours by the phone numbers specified in the Insurance Contract and forward the documents available to the number indicated by them and by other means of forwarding (fax, mail, e-mail) to the Insurer/Service Company.

36. If the Insurer deems it necessary to appoint its lawyer or other authorized person to protect the interests of the Insured Person, provide the specified person with all information and documentation and issue a power of attorney for the right to represent the interests of the Insured person in court.

In the process of record-keeping on the fact of causing harm, the Insured Person and his/her authorized representatives are obliged to follow the instructions of the Insurer and/or the Service Company, if such instructions have taken place.

37. If, as a result of non-fulfillment or improper fulfillment by the Insured Person or the Policyholder of their duties, including in terms of the terms of notification, the effective protection of the interests of the Insured Person by the Insurer has become impossible or difficult, the Insurer has the right to refuse payment of insurance compensation, or to reduce its amount.

38. Conditions for payment of insurance compensation for the "Civil Liability" risk

38.1. In order to receive an insurance payment, the Insured Person (Policyholder) is obliged to submit to the Insurer, no later than 30 (Thirty) calendar days from the date of occurrence of the insured event, an Application for payment in the form established by the Insurer with the attachment of the originals of the following documents:

38.1.1. original Insurance Contract (Insurance Policy);

38.1.2. international passport of the Insured person with marks of crossing the border of the permanent place of residence, to confirm the presence of the Insured person in the insurance territory during the occurrence of the insured event;

38.1.3. internal passport - for citizens of the Russian Federation;

38.1.4. court decision on compensation for damage to third parties that has entered into force if the case for compensation for damage has been settled in court;

38.1.5. originals of documents previously submitted to the Insurer and/or the Service Company in the form of copies or by facsimile or electronic communication;

38.1.6. written explanations of the circumstances and other documents necessary to confirm the fact of the insured event and the amount of losses incurred (damage caused);

38.1.7. invoices for telephone conversations with the Service Company by phone numbers specified in the Insurance Contract;

38.1.8. details of the current account of the Policyholder (Insured person).

39. If the information contained in the documents provided by the Policyholder (Insured Person) is not sufficient for the Insurer to make a decision on the recognition or non-recognition of the event as an insured event and/or determining the amount of damage, the Insurer has the right to extend the terms of consideration of documents for decision-making and in writing request additional documents from the Policyholder (Insured Person) and other institutions (or copies thereof), as well as the right to conduct an independent investigation.

40. After receiving all the necessary documents and information (clauses 38.1, 39 of these Conditions) the Insurer:

- within 20 working days (unless another period is specified in the Insurance Contract) recognizes the event as an insured event, draws up and approves an insurance act indicating the amount and procedure for making insurance payments, or decides not to recognize the event as an insured event and refuse insurance payment.

- within 10 working days from the moment the Insurer makes a decision to recognize the event as an insured event, makes an insurance payment. If the event is not recognized as an insured event, the Insurer within 3 working days sends the Policyholder (Insured Person) a written refusal to pay, indicating the points of the Insurance Rules and/or Insurance Conditions on the basis of which the decision was made to refuse the insurance payment.

41. Payment of insurance compensation is carried out if the Insured Person has reported the occurrence of an insured event in accordance with the established procedure and has complied with all the requirements provided for in these Insurance Conditions.

42. The insurance payment is determined in the amount of real damage within the limits of the insured amount and the compensation limit established under the Insurance Contract for the Insured Person.

43. If the damage caused as a result of an insured event is compensated by other persons (including under life, health, property insurance contracts), the insurance payment is made in the amount of the difference between the amount to be reimbursed to third parties under the Insurance Contract and the amount compensated by other persons.

44. Payment of insurance compensation in part of the amounts due for compensation for damage to the life, health and property of a third party is made to the injured third party, and in the event of his/her death – to the heirs.

45. If the Insured Person (Policyholder) has independently settled the claims of third parties with the written consent of the Insurer, the insurance indemnity is paid to the Insured Person (Policyholder) subject to the provision of documents confirming the expenses and costs incurred.

46. Payment of insurance compensation in terms of damage reduction costs and court costs is carried out to the Insured person whose liability is insured.

47. The procedure and form of payment of insurance compensation are determined by agreement between the Insurer and the third party to whom the damage was caused.

The Insured person has the right to obtain from the Insurer all information concerning the procedure and form of payment of insurance compensation to a third party.

SECTION VII. DISPUTE RESOLUTION PROCEDURE. RESPONSIBILITY OF THE PARTIES

48. All disputes arising between the parties to the Contract are considered in accordance with the procedure provided for by the current legislation of the Russian Federation.

48.1. If there are disagreements between the Policyholder (Beneficiary) and the Insurer regarding the fulfillment by the latter of its obligations under the Insurance Contract before filing a claim against the Insurer, the Policyholder (Beneficiary) sends the claim to the Insurer with the documents attached to it and substantiating the stated claims.

48.2. The claim shall be accompanied by documents that comply with the requirements of the legislation of the Russian Federation for their design and content, provided for by the Insurance Rules (conditions of the Insurance Contract) and confirming the validity of the claims of the Policyholder (Beneficiary).

48.3. The claim of the Policyholder (Beneficiary) with the documents attached to it is submitted or sent to the address of the Insurer at the place of acceptance of the insured event statement from the Policyholder (Beneficiary). The claim of the Policyholder (Beneficiary) with the documents attached to it is subject to consideration by the Insurer within 15 (fifteen) working days from the date of receipt.

48.4. If the disagreement that has arisen at the time of contacting the Insurer is subject to pre-trial consideration by the Commissioner for the Rights of Consumers of Financial Services in accordance with the Federal Law "On the Commissioner for the Rights of Consumers of Financial Services", the Policyholder (Beneficiary) shall, before sending the financial commissioner an appeal, send the Insurer a claim with documents attached to it and substantiating his/her claim in written or electronic form.

48.5. The Insurer is obliged to consider the application of the Policyholder (Beneficiary), and send him/her a reasoned response on satisfaction, partial satisfaction or refusal to satisfy the claim:

- within 15 (fifteen) working days from the date of receipt of the claim, if it is sent electronically in a standard form, which is approved by the Council of the Financial Commissioner's Service, and if no more than 180 (one hundred and eighty) days have passed since the date of the violation, on the merits of which there is a dispute;

- within 30 (thirty) days from the date of receipt of the claim in other cases. In cases provided for by the Law on the Commissioner for the Rights of Consumers of Financial Services, the Policyholder (Beneficiary) has the right to file claims against the Insurer in court only after receiving a decision on the appeal from the financial commissioner.

48.6. Appendices to these Insurance Conditions are an integral part of these Conditions:

Appendix No. 1 – Description of insurance programs for "Medical and other emergency expenses" risk.

Appendix No. 2 – Table of the amount of payments for the "Accident" risk.

Перевод данного текста с русского языка на английский язык выполнен мной, переводчиком Исмаиловым Дмитрием Эльдаровичем, верность перевода подтверждаю.

____

The translation of this text from Russian to English was performed by me, translator Ismailov Dmitriy Eldarovich, I confirm the correctness of the translation.

______/signature/_______

Российская Федерация

Город Москва

Восемнадцатого ноября две тысячи двадцать второго года.

Я, Бакулина Юлия Николаевна, нотариус города Москвы, свидетельствую подлинность подписи переводчика Исмаилова Дмитрия Эльдаровича.

Подпись сделана в моем присутствии.

Личность подписавшего документ установлена.

Зарегистрировано в реестре:

№ 77/1794-н/77-2022- 16-2010

Уплачено за совершение нотариального действия: 400 руб. 00 коп.

__________________ Ю.Н. Бакулина

The Russian Federation

The city of Moscow

18.11.2022

I, Bakulina Julia Nikolaevna, notary of the city of Moscow, certify the authenticity of signature, made by the translator Ismailov Dmitriy Eldarovich.

The signature was made in my presence.

His identity is established.

It is registered in the register under:

№ 77/1794-н/77-2022-

Paid for a notarial act: 400 rubles.

______/**signature**______ J. N. Bak

Seal: Notary of Moscow
Bakulina J. N.
TIN 503202618920

Notary /**signature/**

Seal: Notary of Moscow
Bakulina J. N.
TIN 503202618920