OPŠTI USLOVI ZA OSIGURANJE PUTNIKA ZA VREME PUTA I BORAVKA U INOSTRANSTVU
U-OPI/12-12

triglav

Član 1. OPŠTE ODREDBE

(1) Opšti uslovi za osiguranje putnika za vreme puta i boravka u inostranstvu (u daljem tekstu: Opšti uslovi) su sastavni deo ugovora o osiguranju zaključenog između ugovarača osiguranja i „Triglav osiguranja "a.d.o. (u daljem tekstu: Osiguravač);

(2) Izrazi u ovim uslovima imaju sledeće značenje:

Osiguravač – Triglav osiguranje a.d.o, sa kojim je zaključen Ugovor o osiguranju;

Ugovarač osiguranja - pravno ili fizičko lice koje je sa osiguravačem zaključilo ugovor o osiguranju putnika za vreme puta i boravka u inostranstvu;

Osiguranik - fizičko lice u čiju korist je zaključeno osiguranje;

Polisa – Ugovor o osiguranju putnika za vreme puta i boravka u inostranstvu, kojim se ugovarač osiguranja obavezuje da će osiguravaču platiti ugovoreni iznos (premiju), dok se osiguravač obavezuje da će po nastupanju osiguranog slučaja, osiguraniku nadoknaditi troškove nužnog medicinskog tretmana kao i troškove prevoza, ali najviše do ugovorene sume osiguranja, kao i pružiti putnu i pravnu asistenciju;

Suma osiguranja - maksimalna obaveza Osiguravača po nastupanju osiguranog slučaja (štetnom događaju);

Osigurani slucaj - nastanak događaja kojim se ostvaruje rizik koji je pokriven Ugovorom o osiguranju. Osigurani slucaj mora biti buduci, neizvestan i nezavisan od isključive volje osiguranika i ovaj događaj se mora desiti u okviru trajanja osiguravajućeg pokrića;

Asistentska kompanija (Centar za asistenciju - pomoć) - ugovorni partner osiguravača koji organizuje pomoć pri nastanku osiguranog slučaja asistencije, koga osiguranik mora o tome da obavesti putem telefona.

Član 2. PREDMET I OBIM OSIGURANJA

(1) Osiguravajuće pokriće obuhvata pružanje putnih i pravnih usluga, troškove nužnog medicinskog tretmana kao i troškove prevoza zbog nepredviđene bolesti ili njenih posledica, koja je počela ili nastala na putu ili boravku u inostranstvu;

(2) Osigurani slučaj nepredviđene bolesti počinje sa početkom lečenja a završava kada, po mišljenju lekara, lečenje više nije potrebno ili kada se Osiguranik može bezbedno transportovati u zemlju prebivališta na dalje lečenje;

(3) Ukoliko se lečenje odnosi na bolest ili posledicu nezgode koja sa prethodnom nije u uzročnoj vezi, osiguravač će to smatrati novim osiguranim slučajem

Član 3. ZAKLJUČIVANJE I OTKAZ UGOVORA O OSIGURANJU

(1) Osiguranje se zaključuje pre početka putovanja. Osiguranja zaključena posle početka putovanja nisu važeća.
Izuzetno od prethodnog stava, osiguranje je važeće u slučajevima kada se vrši zamena postojeće polise novom uz uslov da nema prekida osiguranja i da osigurani slučaj nije nastupio

(2) Osiguranje je zaključeno kada osiguravač ili lice koje je on ovlastio, izda odobrenu polisu osiguranja. Kada se ugovor o osiguranju zaključuje na daljinu, osiguravač može da smatra da je osiguranje zaključeno samim plaćanjem premije

(3) Osiguranje može da zaključi lice koje je domaći ili strani državljanin, koji ima prebivalište, odnosno privremeni boravak ili stalno nastanjenje u Republici Srbiji

(4) Osiguranik može da otkaže ugovor o osiguranju pre početka putovanja, odnosno početka perioda osiguranja, ukoliko ne dobije vizu za putovanje u zemlju koja je ovu vrstu osiguravajućeg pokrića zahtevala
Osiguranik može da otkaže ugovor o osiguranju i posle početka putovanja, odnosno perioda osiguranja ukoliko je ambasada odbila izdavanje vize zadržavajući pasoš ili primerke polise.
U oba slučaja osiguranik podnosi potvrdu ambasade o odbijanju ili daje osiguravaču na uvid pasoš radi utvrđivanja dokaza da nema vizu za zemlju navedenu u polisi kao zemlju u kojoj važi osiguravajuće pokriće

(5) Osiguranik može da otkaže ugovor o osiguranju ukoliko otkaže putovanje, uz podnošenje odgovarajućih dokaza, i u slučaju:
1) hospitalizacije osiguranika pre putovanja
2) smrtnog slučaja člana uže porodice
3) poziva osiguranika na vojnu vežbu
4) dobijanja sudskog poziva
5) otkaza putovanja od strane turističke agencije
6) gubitka pasoša

Član 4. POČETAK I TRAJANJE OSIGURAVAJUĆEG POKRIĆA

(1) Osiguranje počinje u 00.00 časova dana koji je u polisi naveden kao dan početka osiguranja, ali ne pre nego što Osiguranik pređe granicu Republike Srbije na putu u inostranstvo. Osiguranje počinje, ukoliko je do tada plaćena premija osiguranja. Ukoliko premija osiguranja do tada nije plaćena, osiguranje počinje u 00.00 časova narednog dana od dana kada je plaćena premija osiguranja.

(2) Osiguravajuće pokriće prestaje prelaskom granice Republike Srbije po završetku boravka u inostranstvu, a najkasnije istekom 24.00 h dana koji je u polisi naveden kao dan prestanka osiguranja

(3) Osiguranje ni u kom slučaju ne važi u Republici Srbiji

(4) Osiguranje ne važi na teritoriji zemlje čiji je Osiguranik državljanin i u kojoj ostvaruje pravo na redovnu zdravstvenu zaštitu

(5) Putnici stariji od 70 godina mogu zaključiti Ugovor sa maksimalnim trajanjem 60 dana

Član 5. PLAĆANJE I POVRAT PREMIJE OSIGURANJA

(1) Ugovarač osiguranja je dužan da plati premiju osiguranja neposredno po dobijanju polise osiguranja

(2) Kada se premija uplaćuje preko banke ili pošte, smatra se da je uplaćena u 24.00 h dana kada je uplata podnela banci ili pošti

(3) Osiguranik ima pravo na povrat premije u slučaju otkazivanja ugovora o osiguranju shodno odredbama tačaka 4) i 5) člana 3. ovih uslova i to:
- 100% iznosa uplaćene premije ukoliko je ugovor o osiguranju otkazan pre početka putovanja, odnosno početka perioda osiguranja;
- 70% iznosa uplaćene premije ukoliko je ugovor o osiguranju otkazan posle početka perioda osiguranja

(4) Osiguranik ima pravo na povrat premije, u slučaju da podnese zahtev osiguravaču pre početka putovanja, u visini koja predstavlja razliku između premije koja je plaćena i premije koja odgovara stvarnom trajanju vize koju je ambasada odobrila, a koji je kraći od perioda za koji je plaćena premija. Razlika je plativa po poništavanju stare polise i pošto je osiguranik sa osiguravačem zaključio novo osiguranje za period odobrenog trajanja vize
U svakom slučaju osiguranik je dužan dostaviti Osiguravaču na uvid putnu ispravu i neophodnu dokumentaciju

(5) Osiguranik ni u kom slučaju nema pravo na povrat premije ukoliko je po ugovoru o osiguranju nastupio osigurani slučaj

Član 6. OBAVEZE OSIGURAVAČA

(1) Osiguravač nadoknađuje osiguraniku - osim u slučajevima navedenim u članu 8. ovih uslova – razumne i uobičajene troškove nužnog medicinskog tretmana i transportne troškove ostvarene za vreme njegovog putovanja i boravka u inostranstvu.
Razumnim i uobičajenim troškovima smatraju se oni troškovi medicinskog lečenja (tretmana), koji nisu veći od opšteg nivoa troškova u sličnim situacijama na tom području, kada se radi o istom ili sličnom medicinskom tretmanu

(2) Kao troškovi nužnog medicinskog tretmana (ili medicinske asistencije) ukoliko je potreban i odobren prema mišljenju asistentske kompanije u smislu ovih uslova smatraju se isključivo troškovi:
(a) medicinskog tretmana;
(b) za lekove i zavoje koje je prepisao lekar;
(c) za medicinska pomagala neophodna za lečenje (na primer, flasteri, gips, ortopedska pomagala, zavoji, štake) koja je prepisao lekar;
(d) za rendgensku dijagnostiku;
(e) za ambulantno pružanje medicinskih usluga ukoliko ambulanta raspolaže dijagnostičkom i terapeutskom opremom i radi po metodama koje su naučno priznate i klinički ispitane u zemlji privremenog boravka osiguranika. Osiguranik se mora uputiti u bolnicu u mestu njegovog privremenog boravka ili u najbližu odgovarajuću bolnicu. Ambulantno lečenje ne podrazumeva kontrolne preglede osim u slučajevima da ih odobri lekar cenzor kao neophodne (u situacijama pogoršanja zdravstvenog stanja osiguranika i sl.);
(f) prevoz do bolnice;
(g) operisanja (uključujući i indirektne troškove operacije);
(h) bolničkog lečenja (hospitalizacija) u ustanovi koja se smatra bolnicom, pri čemu se koristi bolnica u mestu u kom je osiguranik odseo ili najbliža odgovarajuća bolnica;
(i) hitne stomatološke intervencije potrebne za otklanjanje akutnog bola zbog bolesti ili oštećenja zuba uključujući i vađenje zuba i jednostavne opravke proteza, isključujući završne radove na zubu ili krunici, ali ne i izradu veštačkih zuba ili krunica, najviše do 150 EUR;
(j) kod alergijskih reakcija bez komplikacija i kod opekotina od sunca, na ime troškova lekarskog tretmana i medicinskih sredstava, osiguranik sam plaća iznose do 50 EUR i deo troškova koji prelazi 100 EUR, tako da maksimalna obaveza osiguravača iznosi 50 EUR

(3) Kao troškovi prevoza u smislu ovih uslova smatraju se isključivo:
(a) nužni troškovi za prevoz osiguranika u Republiku Srbiju, učinjeni po nalogu lekara u slučaju da ne postoji mogućnost pružanja dovoljne medicinske nege u mestu posete osiguranika, ili u najbližoj okolini, a što može uticati na pogoršanje pacijentovog zdravlja i u slučajevima kada je osiguranik sposoban za putovanje a u cilju uštede troškova po bolničkom danu. Nezavisno od toga, takođe se priznaju dodatni troškovi za pratioca, ukoliko je potrebna medicinska pratnja ili je predviđena zakonom;
(b) u slučaju smrti - nužni troškovi prevoza u Republiku Srbiju ili nužni troškovi sahrane u mestu smrti u inostranstvu, uz isključenje sahrane u zemlji prebivališta ali ne više od iznosa ugovorenog i navedenog u polisi osiguranja.

(4) Maksimalna obaveza osiguravača za pojedinačno putovanje određena je sumom osiguranja navedenoj na polisi osiguranja
Sume osiguranja se razlikuju zavisno od programa osiguranja i to:
a) Osnovni program osiguranja
Ukupna suma osiguranja najviše 15 000 EUR, od čega za troškove prevoza najviše 3 600 EUR;
b) Nadstandardni program osiguranja
Ukupna suma osiguranja najviše 30 000 EUR, od čega za troškove prevoza najviše 7 200 EUR ;
c) Poseban program osiguranja za Bugarsku, Tursku, Egipat i Tunis
Ukupna suma osiguranja najviše 10 000 EUR, od čega za troškove prevoza najviše 2 400 EUR

(5) Ukoliko je za isti period osiguranja, zaključeno više ugovora o osiguranju za jednog osiguranika, osiguravač ima obavezu iz osiguranja samo po ugovoru sa najvišom sumom osiguranja

Član 7. PUTNA I PRAVNA ASISTENCIJA

(1) Osiguravajuće pokriće putne asistencije obuhvata pružanje sledećih usluga:
1. informisanje o zemlji u koju se putuje;
2. razne savetodavne usluge u vezi hitnog putovanja;
3. obezbeđenje usluga prenosa poruka;
4. informisanje u slučaju gubitka ili kašnjenja prtljaga;
5. informacije u vezi rent-a-car usluga

(2) Osiguravajuće pokriće obuhvata pružanje pravnih usluga:
1. organizovanje pravne pomoći, upućivanjem na advokata, kada je osiguraniku neophodna pravna zaštita za vreme boravka u inostranstvu – troškove advokatskog honorara plaća osiguranik;
2. upućivanje osiguranika na predstavnike lokalnih organa, ambasada i konzulate;
3. obezbeđenje usluga prevodioca - troškove prevoda plaća osiguranik;
4. administrativna pomoć u vezi ličnih i putnih isprava

(3) Usluge asistencije iz stava (1) i (2) ovog člana osiguranik može da koristi pozivanjem brojeva asistentske kompanije u skladu sa članom 9. ovih Uslova.

Član 8. ISKLJUČENJA IZ OSIGURANJA

(1) Osiguravač nije u obavezi da nadoknadi troškove medicinskog tretmana i troškove prevoza nastale zbog:
- lečenja raka, SIDE (AIDS-a) i veneričnih bolesti, kao i troškovi lečenja zadnjih stadijuma hronične bolesti;
- hroničnih, povratnih bolesti ili njihovih posledica, kao i posledica bolesti koje su postojale ili su bile poznate u vreme zaključenja ugovora o osiguranju;
- bolesti, uključujući njihove posledice, kao i posledica nezgode koje su prouzrokovane ratom, invazijom, terorističkim aktivnostima, građanskim ratom, činom sabotaže ili terorizma, pobuna, revolucije, ustanka, vojne i druge uzurpacije vlasti;
- namerne radnje osiguranika, samoubistva i pokušaja samoubistva ili duševne bolesti – neuračunljivosti osiguranika;
- bolesti ili nezgode koje su posledica aktivnog učešća osiguranika u kriminalnim radnjama, ako je namerno prouzrokovana postupkom osiguranika ili posledica uživanja alkohola ili drugih opijata. Smatra se da je osiguranik pod uticajem alkohola ili opijata ako je posle nastanka osiguranog slučaja utvrđeno prisustvo alkohola u krvi više od 0,3 ‰, odnosno ako su pronađeni tragovi narkotičkih sredstava;
- bolesti ili nezgode koje su posledica upotrebe neregistrovanih lekova, ili korišćenja lekova bez uputstva lekara;
- odstranjivanja estetskih defekata ili telesnih anomalija, preventivnog vakcinisanja, dezinfekcije, dijagnostikovanja i testiranja;
- boravka u banjama, rehabilitacionim centrima, sanatorijumima, zdravstvenim centrima, medicinskim institutima i kućama i sličnim institucijama za zdravstvenu rehabilitaciju;
- psihoanalitičkih i psihoterapeutskih tretmana;
- trudnoće i tegoba tipičnih za trudnoću, izuzev u slučaju akutnog, nenormalnog toka trudnoće i njenih posledica, kada osiguravač pokriva troškove lečenja i medicinskih mera za direktno otklanjanje opasnosti po život majke i deteta, pod uslovom da trudnica na početku nenormalnog toka trudnoće nije navršila 36 godina života, ni trideset nedelja trudnoće;
- praćenja ili prekida trudnoće, porođaja i njegovim posledicama;
- nege pružene od strane osiguranikovog partnera, dece ili roditelja;
- rehabilitacije i proteza;
- zbrinjavanja koje nije navedeno u članu 6. ovih Uslova;
- upravljanja kamionom, autobusom, avionom, vozom, brodom i drugim vozilom na motorni pogon od strane profesionalnog vozača, do visine štete u iznosu od 100 EUR (franšiza);
- bolesti ili nezgode koje osiguranik zadobije, odnosno pretrpi aktivno učestvujući u sportskim takmičenjima ili pripremama koje organizuju sportski savezi ili društva osim ako je to izričito ugovoreno;
- osiguranikovog bavljenja rizičnim i opasnim sportovima ili aktivnostima (ekstremni sportovi ili slično), kao što su: (lov, akrobacije, planinarenje, ronjenje, paragljajding, speleologija, padobranstvo, skijaški skokovi, skijanje na vodi, vožnja bobom, akrobatsko skijanje, hokej, klizanje na ledu, vožnja bagijem, vodenim skuterima, bavljenje eksplozivom i vatrometom, jedriličarstvo, auto trke, motociklističke trke i slično);
- vožnje motorom osiguranika, bez odgovarajuće vozačke dozvole i zaštitne opreme. U slučaju nastanka osiguranog slučaja prilikom prijave povrede obavezno se dostavlja i kopija vozačke dozvole i urađen alko test;
- boravka u bolnici od dana kad bi asistentska kompanija bila u stanju i od kada bi imala pravo da izvrši repatrijaciju osiguranika;
- smeštaja u jednokrevetnu ili privatnu sobu u bolnici, osim ukoliko medicinski tim smatra da je to neophodno;
- osiguranikovog odbijanja da se pridržava instrukcija koje dobije od medicinskog tima, ili odbijanje datuma, vrste i načina repatrijacije koju odredi asistentska kompanija nakon konsultacije sa lekarom, odnosno medicinskom ustanovom koja leči osiguranika u inostranstvu;
- samovoljno organizovane repatrijacije, bez prethodno dobijenog odobrenja od strane osiguravača, odnosno asistentske kompanije;
- neprijavljivanje osiguranog slučaja osiguravaču, odnosno asistentskoj kompaniji u skladu sa članom 9. a za nastale troškove veće od 500 EVRA.

(2) U svakom slučaju, Osiguravač nije u obavezi za štete koje su pokrivene po osnovu drugog osiguranja, kao i za štete neimovinske prirode

(3) Asistentska kompanija ima pravo da odbije isplatu naknade u slučaju da:
a) osiguranik ne ispuni svoje obaveze iz ugovora ili ne ispoštuje instrukcije koje dobije od asistentske kompanije;
b) osiguranikova izjava, koja predstavlja osnovu za zaključenje polise ili koja nastane u procesu prijave štete, bude lažna, neistinita, iskaza, ili prikriva činjenice, u cilju namerne prevare i sl.

Član 9. OBAVEZE OSIGURANIKA ILI UGOVARAČA OSIGURANJA

(1) U slučaju potrebe za asistencijom, čim se dogodi osigurani slučaj ili postoji mogućnost dešavanja, osiguranik je u obavezi da izvrši prijavu osiguranog slučaja. Osiguranik prijavu osiguranog slučaja vrši na sledeći način:
1) poziva asistentsku kompaniju;
2) vrši identifikaciju davanjem osnovnih podataka o sebi (ime i prezime, broj pasoša, polise i sl.);
3) šalje kopiju polise na broj faksa koji se nalazi na polisi;
4) dostavlja broj telefona i adresu u inostranstvu na kojoj može biti kontaktiran;
5) ukratko opisuje vrstu i način nastanka osiguranog slučaja
6) prihvata lečenje u zdravstvenoj ustanovi u koju ga uputi osiguravač, odnosno asistencijska kompanija.

(2) Osiguranik je dužan da u slučaju ambulantnog lečenja koristi usluge lekara i zdravstvenih ustanova sa kojim osiguravač ili asistentska kompanija sarađuje kao i da prati njihove dalje instrukcije kako bi se sproveo potreban postupak lečenja i obezbedile usluge asistencije. U suprotnom, osiguravač neće izvršiti direktnu nadoknadu troškova ambulantnog lečenja zdravstvenoj ustanovi, već će, ukoliko se utvrdi osnov i obim za priznavanje osiguranog slučaja, troškove refundirati osiguraniku nakon povratka u zemlju prebivališta.

(3) Takođe, ukoliko u slučaju bolničkog lečenja, osiguranik sam izabere bolnicu bez konsultacije sa osiguravačem, osiguravač ima pravo da odbije direktnu nadoknadu troškova bolničkog lečenja zdravstvenoj ustanovi i da izvrši refundaciju troškova po povratku osiguranika u zemlju prebivališta, na način definisan članom 10. ovih Uslova (Osiguravač ima pravo da smanji iznos nadoknade za štetu nastalu usled toga što osiguranik nije ispunio svoje obaveze definisane ovim uslovima i ugovorom o osiguranju.)

(4) Ako nije moguće hitno telefonirati pri konsultovanju lekara ili odlasku u bolnicu, osiguranik treba da pokaže lekaru ili osoblju bolnice polisu osiguranja, koji po pravilu vrše prijavu osiguranog slučaja pozivanjem dežurnog centra asistentske kompanije.

(5) U svakom slučaju, kada iz opravdanih razloga, zbog iznenadne bolesti ili nesrećnog slučaja, nije u mogućnosti da prijavi osigurani slučaj, potrebno je izvršiti prijavu u roku od 48 sati od nastanka osiguranog slučaja i asistentskoj kompaniji dati informacije o nazivu i adresi bolnice, imenu lekara koji leči osiguranika i odgovarajuće brojeve telefona, u suprotnom osiguravač ne garantuje da će troškovi lečenja biti nadoknađeni.

(6) Ako osiguranik nije u mogućnosti da izvrši prijavu osiguranog slučaja asistentskoj kompaniji, prijava izvršena najbrže moguće, ali ne nakon roka navedenog u prethodnom stavu ovog člana, učinjena od strane bliske osobe, policije, sudskog organa, bolničke ustanove ili bilo koga ko mu je pritekao u pomoć, važi kao da je osiguranik lično izvršio prijavu.

(7) U slučaju kada je, zbog iznenadne bolesti ili nesrećnog slučaja, osiguranik smešten u bolnicu radi lečenja (hospitalizacija) a zbog urgentno teškog zdravstvenog stanja, praćenog poremećajem svesti nije u mogućnosti da izvrši prijavu, saglasno stavu (5) i (6) ovog člana, osiguravač će priznati dodatni rok za prijavu osiguranog slučaja ali ne kasnije od 7 dana od dana nastanka osiguranog slučaja i obavezno pre izlaska iz bolnice i pre povratka u zemlju prebivališta.

(8) Na sve prijave posle rokova definisanih prethodnim stavovima ovog člana primenjuju se odredbe iz Člana 10. ovih Uslova. U slučaju da osiguranik iz objektivnih razloga ne prijavi osigurani slučaj asistentskoj kompaniji, već troškove lečenja plati sam, osiguravač će ove troškove nadoknaditi osiguraniku po povratku u zemlju prebivališta, ali najviše do iznosa od 500 Eura.

(9) Odštetni zahtev mora biti podnet u roku od tri meseca po završetku lečenja, odnosno od prevoženja u zemlju stalnog boravka ili smrtnog slučaja.

(10) Ugovarač osiguranja ili osiguranici su dužni da na zahtev osiguravača daju sve podatke potrebne za utvrđivanje osiguranog slučaja ili obima osiguravajućeg pokrića.

(11) Ugovarač osiguranja ili osiguranici ovlašćuju osiguravača da prikupi sve potrebne podatke od trećih lica (doktora, stomatologa, medicinskih radnika, medicinskih institucija svih vrsta, institucija zdravstvenog osiguranja, zdravstvenih i socijalnih službi). Osiguranik oslobađa medicinsko osoblje koje ga je pregledalo pre i posle nastanka osiguranog slučaja profesionalne obaveze čuvanja tajne i slaže se da bolnica ili zdravstvena ustanova koja mu je pružila negu saopšti osiguravaču ili asistentskoj kompaniji sve neophodne informacije vezane za osiguranikovo zdravstveno stanje.

Član 10. ISPLATA NAKNADE ŠTETE

(1) Kad nastane osigurani slučaj osiguravač je dužan da ispuni svoju obavezu pod uslovom da su, pored dokaza o osiguravajućem pokriću, podneti i dokazi navedeni u tačkama od (2) do (4) ovog člana.

(2) Osiguravaču se podnose originalni računi o nastalim troškovima. Ukoliko se dostavljaju duplikati računa, isti moraju biti overeni od strane ustanove koja je izdala originalne račune.

(3) Na računu mora biti upisano ime osiguranika, opis bolesti, pojedinačno navedeni medicinski tretmani sa podacima o lečenju, na računu za lekove mora biti jasno vidljiv prepisani lek, cena i pečat apoteke. Za stomatološke tretmane, računi treba da sadrže opis lečenih zuba i izvršenih intervencija na njima.

(4) Zahtev za naknadu troškova prevoza ili sahrane mora biti utemeljen na računima. U slučaju smrti, sa urednom smrtovnicom i sa izveštajem nadležnog lica iz koga se vidi uzrok smrti, a kod zahteva za naknadu troškova prevoza bolesnika u Republiku Srbiju sa potvrdom lekara i opisom bolesti. Potvrda lekara pored toga mora sadržati dokaz da je povratak, sa medicinskog stanovišta bio nužan.

(5) Ako je osiguranik prilikom zaključivanja osiguranja netačno prijavio podatke o svojim godinama i njegova starost prelazi 65 godina, naknada iz osiguranja se smanjuje srazmerno odnosu plaćene premije i premije koja odgovara starosti osiguranika.

(6) Ukoliko osiguranik ne izvrši prijavu osiguranog slučaja asistentskoj kompaniji, u skladu sa članom 9. ovih Uslova, već sam izabere zdravstvenu ustanovu odnosno lekara i plati troškove lečenja, osiguravač će nadoknaditi osiguraniku razumne i uobičajene troškove definisane Članom 6, nakon povratka u zemlju prebivališta, maksimalno do iznosa od 500 EVRA i pod uslovom da je odštetni zahtev podnet u roku od tri meseca od završetka lečenja.

(7) U slučaju da bolnica ili lekar poseduje originalnu polisu osiguranika, a ne izvrši prijavu osiguranog slučaja osiguravaču u rokovima navedenim u članu 9. ovih Uslova, a osiguranik bude otpušten iz bolnice ili se vrati u zemlju prebivališta, bolnica, odnosno lekar, neće imati pravo da direktnu naknadu troškova nastalih u vezi sa osiguranim slučajem od osiguravača ili asistentske kuće.

(8) Naknada štete obračunava se u dinarskoj protivvrednosti po srednjem kursu NBS na dan konačnog rešavanja štete

Član 11. PRESTANAK OSIGURAVAJUĆEG POKRIĆA

(1) Osiguravajuće pokriće prestaje:
- istekom važenja polise ili
- povratkom u zemlju Repuliku Srbiju ili
- prevozom u smislu odredaba pod a) tačke (3) člana 6

(2) Kao kraj boravka u inostranstvu smatra se trenutak prelaska državne granice Republike Srbije.

(3) Ukoliko se lečenje bez prekida nastavlja i po isteku važenja polise, osiguranjem su pokriveni i troškovi tog lečenja, ali ne više od 4 (četiri) nedelje i pod uslovom da obolelog osiguranika nije bilo moguće prebaciti u Republiku Srbiju ili ako je prebacivanje odloženo zbog uzroka na koje osiguranik nije mogao uticati.

Član 12. USTUPANJE PRAVA ILI PORAVNANJE PO ODŠTETNOM ZAHTEVU

(1) Ukoliko ugovarač osiguranja ili osiguranik prema trećem licu istakne odštetne zahteve po drugom osnovu,a pokriveni su osiguranjem te zahteve mora pismenim putem da ustupi osiguravaču do visine isplaćene naknade iz osiguranja

(2) Ukoliko ugovarač osiguranja ili osiguranik odustane od takvog zahteva, ili prava za podnošenjem odštetnog zahteva bez saglasnosti osiguravača, gubi pravo na srazmeran deo naknade iz osiguranja

(3) Ukoliko ugovarač osiguranja ili osiguranik primi odštetu od lica odgovornog za štetu po ovim Uslovima, osiguravač ima pravo da za taj iznos umanji naknadu iz osiguranja
Ako osiguranik primi naknadu od trećih osoba u vezi osiguranog slučaja, Osiguravač zadržava pravo da odbije takvu naknadu od naknade koju je u obavezi da naknadi u skladu sa Uslovima

(4) Ugovarač osiguranja ili osiguranik ne mogu založiti ni ustupiti potraživanja iz osiguranja.

Član 13. ZAŠTITA LIČNIH PODATAKA

(1) U skladu sa Zakonom o zaštiti podataka o ličnosti, ugovarač osiguranja potpisom na polisi daje saglasnost na korišćenje ličnih podataka iz ponude, odnosno pristupne izjave, u zbirnim podacima koje prikuplja, vodi i održava osiguravač i druga sa njim povezana lica, ovlašćene agencije i posrednici.

(2) Podatke iz stava (1) ovog člana osiguravač obrađuje i razmenjuje sa asistentskom kompanijom sa kojom ima zaključen ugovor o poslovnoj saradnji, u smislu ovih uslova osiguranja. Iste može dostavljati reosiguravaču ili saosiguravaču, odnosno drugim licima koja po prirodi posla ostvaruju uvid ili obrađuju lične podatke u skladu sa zakonskim propisima.

(3) Osiguravač sve podatke o ugovaraču i osiguraniku brižno čuva i obrađuje kao poslovnu tajnu, uz primenu svih mera zaštite podataka u skladu sa zakonskim propisima i internim aktima Društva.

(4) Navedeni lični podaci će se koristiti samo dok je na snazi osiguranje i to u svrhu informisanja ugovarača osiguranja o novostima i ponudama osiguravača

Član 14. VANSUDSKO REŠEVANJE SPOROVA

(1) Protiv odluka osiguravača je dozvoljeno ulaganje žalbe. Žalbe se podnose u organizacionoj jedinici osiguravača u kojoj je i zaključeno osiguranje, lično, poštom ili putem osiguravače internet prezentacije.

(2) Žalbe rešava nadležna Komisija za žalbe u skladu sa Pravilnikom o žalbenom postupku osiguravača. Odluka žalbene komisije je konačna.

Član 15. ZAKLJUČNE ODREDBE

1) Za odnose između osiguravača i ugovarača osiguranja koji nisu uređeni ovim Opštim uslovima, primenjuju se zakonske odredbe i odredbe Zakona o obligacionim odnosima

2) U slučaju spora između osiguranika odnosno ugovarača osiguranja i osiguravača, nadležan je isključivo stvarno nadležni sud prema mestu sedišta osiguravača.

GENERAL CONDITIONS FOR PASSENGER INSURANCE DURING TRAVEL AND STAY ABROAD

U-OPI/12-12

Article 1. GENERAL PROVISIONS

(1) General conditions for Passenger Insurance During Travel and Stay Abroad (hereinafter: General Conditions) shall be an integral part of the Insurance Contract made between the Policy Holder and "Triglav osiguranje" a d o (hereinafter: the Insurer)

(2) The terms used in these Conditions shall have the following meanings:

The Insurer - "Triglav osiguranje" a d o with whom the Insurance contract is made ;

The Policyholder - natural or legal person who has entered into a contract with the Insurer on passenger insurance during the travel and stay abroad;

The Insured - a natural person in whose favour the insurance contract is made ;

Policy - Insurance contract on passenger insurance during the travel and stay abroad, under which the Policyholder agrees to pay to the Insurer the agreed amount (premium), while the Insurer agrees to reimburse the Insured, after the occurrence of the insured event, for the costs of the necessary medical treatment and transportation costs, not exceeding the sum insured, as well as provide travel and legal assistance;

The sum Insured - maximum liability of the Insurer upon the occurrence of the insured event (adverse event);

Insured event - the emergence of events bearing a risk that is covered by the insurance contract. The insured event must be uncertain and independent of the exclusive will of the Insured, and this event must occur within the period of insurance coverage;

Assisting Company (Customer Assistance Centre - help) -the Insurer's contractual partner who organizes help during the occurrence of the insured event of assistance, whom the Insured is to notify thereon by telephone

Article 2. SUBJECT AND SCOPE OF INSURANCE

(1) The insurance cover comprises providing of travel and legal services, costs od medical treatment needed, as well as transport costs resulting from a disease unforeseen or consequences thereof, that commenced or occurred during travel or stay abroad

(2) The insured event of unforeseen disease starts at commencement of the treatment and terminates when, according to the opinion of the physician, treatment is no longer needed, or when the Insured person can be safely transported to the country of residence for further treatment;

(3) If the treatment is related to a disease or accident consequences that are not causally related to previous disease or accident, the Insurer shall regard this as a new insured event

Article 3. CONCLUSION AND CANCELLATION OF INSURANCE CONTRACT

(1) The Insurance is concluded prior to the start of the journey. Insurance concluded after the journey has started shall not be valid. Notwithstanding the preceding paragraph, the insurance shall be valid in cases where the existing policy is being replaced with a new one provided that there is no interruption of Insurance and in case when the insured event did not take place

(2) The insurance is concluded when the Insurer or its authorized representative issue a confirmed Insurance Policy. For Insurance Contracts concluded at a distance, the Insurer can consider insurance to be concluded when the premium is paid

(3) Insurance can be concluded with a person who is a domestic citizen or a foreign citizen, who has residence i e temporary or permanent residence in the Republic of Serbia

(4) The Insured may cancel the Insurance Contract before the beginning of the journey, i e the beginning of the insurance period, if he is not granted a visa to travel to a country which had requested this type of insurance cover.
The Insured may cancel the Insurance Contract also after the beginning of the journey, i e the beginning of the insurance period, if the embassy has refused to issue the visa while retaining the passport or copies of the Insurance Policy.
In both cases, the Insured shall submit the certificate of refusal from the embassy or present to the Insurer for inspection the passport, for the purpose of establishing proof that he does not hold a visa for the country listed in the Insurance Policy as the country wherein the insurance cover is valid

(5) The Insured may cancel the Insurance Contract if he cancels the journey, by submitting adequate proof, and in case of:
1) hospitalization of the Insured prior to the journey,
2) death of a member of the immediate family,
3) summons received by the Insured to attend military training,
4) receiving a court summons,
5) cancellation of the journey by the tourist agency,
6) loss of passport

Article 4. START AND DURATION OF THE INSURANCE COVER

(1) Insurance cover starts at 00:00 hours of the day stated in the insurance policy as the insurance commencement day, but not before the Insured has crossed the border of the Republic of Serbia on his journey abroad. The insurance shall commence provided the Insurance Premium has been paid by then. If the Insurance Premium has not been paid by then, the insurance cover starts at 00:00 hours of the day following the day of the payment of the Insurance Premium

(2) Insurance cover ceases by crossing the border of the Republic of Serbia, upon completion of the Insurer's stay abroad ,and at the latest by lapse of 24:00 hours of the day stated as the termination day of the Insurance

(3) Insurance cover shall under no circumstances apply in the Republic of Serbia

(4) Insurance cover shall not apply on the territory of the country whose citizen is the Insurer and in which he/she is eligible to regular health care.

(5) Passengers over 70 years of age may conclude Contract with a maximum duration of 60 days

Article 5. PAYMENT AND REIMBURSEMENT OF THE INSURANCE PREMIUM

(1) The Policy Holder shall pay the Insurance Premium immediately after receipt of the Insurance Policy

(2) If the Insurance Premium is paid via bank or post, it shall be considered paid at 24 00 hours of the day when payment was submitted to the bank or post

(3) The Insured shall be entitled to reimbursement of the Premium in case of cancellation of the Insurance Contract in accordance with provisions of Paragraphs 3) and 4) of Article 3 of these Conditions, as follows:
- 100% of the paid Premium if the Insurance Contract was canceled before the beginning of the journey, i e before the beginning of the insurance period,
- 70% of the paid Premium if the Insurance Contract was canceled after the beginning of the insurance period

(4) The Insured shall be entitled to reimbursement of the Premium in case he submits a request to the Insurer prior to the journey, in the amount representing the difference between the paid Premium and the Premium equivalent to the actual duration of the visa granted by the embassy, which is shorter than the period for which the Premium was paid. The difference shall be payable after the cancellation of the old Insurance Policy and after the Insured has concluded with the Insurer a new insurance for the period of the approved period of validity of the visa. In any case, the Insurer is liable to present to the Insurer a travel document and necessary documentation for inspection

(5) The Insured shall have no obligations whatsoever as to reimbursement of the Premium in case the insured event specified in the Insurance contract has taken place.

Article 6. OBLIGATIONS OF THE INSURER

(1) The Insurer indemnifies the Insured - except in cases as stated in Article 8 of these Conditions – for reasonable and usual costs of the medical treatment needed and transport costs sustained during his travel and stay abroad.
As reasonable and usual costs shall be regarded such costs of medical cure (treatment), that are not higher than the general level of costs in similar situations in that area, related to the same or similar medical treatment.

(2) As costs of the medical treatment needed (or medical assistance) if needed and approved according to the opinion of the Assisting Company according to these Conditions apply exclusively the costs of:
(a) medical treatment;
(b) medicines and bandages prescribed by the physician;
(c) medical aids for cure needed (e g plasters, gypsum orthopedic aids, bandages crutches) if prescribed by the physician;
(d) x-ray diagnostics;
(e) or medical services in a dispensary if the dispensary has sufficient diagnostic and therapeutic facilities and operates according to methods scientifically acknowledged and clinically tested in the country of temporary stay of the Insured. The Insured must be referred to the hospital in the place of his temporary stay or to the closest appropriate hospital. Treatment in a dispensary does not involve control check-ups except in situations when the censor physician approves them as necessary (in situations of deterioration of the Insured's health and the like);
(f) transport to hospital;
(g) operation (including Indirect costs of operation);
(h) hospital treatment (hospitalization) in an institution which is considered a hospital, where the hospital in the place where the Insured is staying or the closest adequate hospital is used;
(i) urgent dental interventions needed for healing acute pain due to dental disease or damage of teeth, including tooth extraction and simple repair of teeth prosthesis excluding finishing of teeth or crowns, but not the production of artificial teeth or crowns, to a maximum of 150 EUR
(j) in allergic reactions without complications and in sunburns, for costs of doctor's treatment and medicinal devices, the Insurer himself pays the sums up to 50 EUR and the part of costs exceeding 100 EUR, so that the maximum liability of the Insurer amounts to 50 EUR.

(3) As transport costs according to these conditions qualify exclusively:
(a) increased transport costs of the Insured to the Republic of Serbia, when transport is ordered by the physician in case when there is no possibility of sufficient medical care in the place visited by the Insured, or in the immediate neighborhood, and when this could affect and worsen the patient's health and in cases when the Insurer is capable of travelling and for the purpose of saving costs per day of hospitalization. Apart from that, also additional cost for the companion shall be refunded if the medical escort is needed or prescribed by Law:
(b) in case of death – increased transport costs needed to the Republic of Serbia or needed increased costs of burial in the foreign country, excluding burials in the country of residence however not exceeding the sum contracted and as stipulated in the Insurance Policy.

(4) The maximum liability of the Insurer per individual journey is determined by the sum insured stated in the Insurance Policy.
Sums insured differ depending on the program of insurance as follows:
a) Basic Insurance program
Total sum insured maximum 15,000 EUR, of which for transport costs maximum 3,600 EUR
b) Above standard Insurance program
Total sum insured maximum 30,000 EUR, of which for transport costs maximum 7,200 EUR
c) Special insurance program for Bulgaria, Turkey, Egypt and Tunisia
Total sum insured maximum 10,000 EUR, of which for transport costs maximum 2,400 EUR

(5) If several insurance contracts have been concluded for the same period for one insured person, the Insurer shall have an obligation of insurance arising only from the contract with the highest amount of insurance

Article 7. TRAVEL AND LEGAL ASSISTENCE

(1) Insurance cover for travel assistance encompasses provision of following services:
1 information about the country traveled to;
2 various advisory services relevant to urgent travel;
3 providing services of message conveyance;
4 information in case luggage is lost or late;
5 information pertaining to rent-a-car services

(2) Insurance cover encompasses providing of legal services:
1 organization of legal assistance by referral to a lawyer, when the Insured requires legal protection during the stay abroad - costs of lawyer fees shall be borne by the Insured;
2 referring the Insured to representatives of local authorities, embassies and consulates;
3 providing services of a translator - costs of translation shall be borne by the Insured;
4 administrative assistance pertaining to personal and travel documents

(3) The Insured can use assistance services from paragraphs (1) and (2) of this Article by phoning the numbers of the Assisting Company stated in Article 9 of these Conditions

Article 8. EXCLUSIONS FROM THE INSURANCE COVER

(1) The Insurer is under no obligation to cover the costs of medical treatment and transport costs due to:
- Treatment of cancer, AIDS and venereal diseases, as well as costs of treatment of the last stage of chronic diseases
- chronic, recurrent diseases or their consequences, and the consequences of diseases that existed or were known at the time of conclusion of the insurance contract;
- diseases, including their consequences, and the consequences of accidents that are caused by war, invasion, terrorist activities, civil war, an act of sabotage or terrorism, rebellion, revolution, insurrection, military or other abuse of power;
- diseases and accidents sustained by the Insured during the period of active participation in sport competitions or preparations organized by sport associations or clubs, except if it has been explicitly agreed upon and a proportionally higher premium has been paid;
- intentional acts of the insured, suicide, attempted suicide or mental illnesses - mental incapacity of the Insured;
- diseases and accidents resulting from the Insured's active participation in criminal acts, if caused on purpose or as a consequence of use of alcohol or other opiates. The Insured is considered to be under the influence of alcohol or drugs if after the occurrence of the insured event the presence of alcohol in the blood of more than 0 3 ‰ was detected, and/or if the traces of narcotics were detected ;
- diseases or injury resulting from the use of unregistered medicines, or the use of drugs without doctor's instructions;
- removal of aesthetic defects or bodily anomalies, preventive vaccinations, disinfection, diagnosis, and tests;
- costs incurred during the stay in spas, rehabilitation centers, sanatoriums, health resorts, health institutions and homes, or similar institutions for health rehabilitation;
- costs of psychoanalytical or psychotherapeutical treatments;
- costs in connection with pregnancy, and symptoms typical of pregnancy, except in acute, abnormal course of pregnancy and its consequences, when the Insurer covers the cost of treatment and medical measures for direct elimination of danger for the life of mother and child, if the pregnant woman has not completed 36 years of age nor 30 weeks of pregnancy at the start of the abnormal course of pregnancy;
- monitoring and termination of pregnancy, childbirth and its consequences;
- care rendered by the Insured's partner, children or parents;
- rehabilitation and prostheses,
- care not defined In Article 6 of these Conditions,
- the driving of a truck, bus, airplane, train, ship, or other motor vehicle by a professional driver, to the amount of losses of 100 EUR (franchise),
- diseases or accident the Insured may gain or suffer from by actively participating in sports competitions or preparations organized by sports associations or organizations unless explicitly contracted otherwise;
- the Insured's participation in risky and dangerous sports or activities (extreme sports, etc), such as: (hunting, acrobatics, mountain climbing, diving, paragliding, caving, paragliding, ski jumping, skiing, riding bob, acrobatic skiing, ice hockey, ice skating, riding buggies, jet skis, dealing with explosives and fireworks, gliding, auto racing, motorcycle racing, etc);
- the Insured's motor driving without an official document and protective gear. In case of occurrence of an insured event when reporting an injury a copy of the official document and performed breath test must be submitted,
- hospital stay from the day when the Assisting Company would be able to and as of which it would have the right to repatriate the Insured,
- accommodation in a single or private room in the hospital, except if the medical team regards this as indispensable,
- the refusal of the Insured to adhere to instructions given him by the medical team, or refusal of a date, type and manner of repatriation determined by the Assisting Company after consulting the doctor and/or medical institution treating the Insured abroad;
- an arbitrarily organized repatriation, without previously obtained approval from the Insurer, and/or Assisting Company,
- failure to report the insured event to the Insurer, and/or Assisting Company in accordance with Article 9 when resulting costs exceed 500 EUR.

(2) In any case, the Insurer has no obligations relevant to damages covered based on other insurance as well as for non-pecuniary damages

(3) The assisting company is entitled to refuse payment of compensation in the event that:
a) the Insured fails to fulfill his obligations under the contract or fails to comply with instructions given by the assisting company;
b) the Insured statement, which is the basis for conclusion or the insurance policy or the statement made during the process of damage reporting, be false, of untrue testimony or conceals the facts, for the purpose of carrying out deliberate deception, etc.

Article 9. OBLIGATIONS OF THE INSURED OR POLICY HOLDER

1) In case if assistance is needed, as soon as the insured event happens or there is the possibility that it may happen, the Insured undertakes to report the insured event. The Insured reports the insured event in the following manner:
1) calls the Assisting Company;
2) identifies himself, by giving the basic data about himself (name, last name, passport number, Policy number etc);
3) sends a copy of the Policy to the telefax number stated on the Policy;
4) submits the telephone number and address abroad at which he can be contacted;
5) briefly describes the type and manner in which the insured event happened;
6) accepts treatment in the healthcare institution to which the Insurer, and/or Assisting Company refer him

2) In case of outpatient treatment, the Insured undertakes the obligation to use the services of doctors and healthcare institutions with which the Insurer or Assisting Company cooperate, as well as follow their further instructions in order to carry out the needed treatment procedure or secure services of assistance. Otherwise, the Insurer will not make direct compensation for costs of outpatient treatment to the healthcare institution, but shall, if the scope and basis for the recognition of the insured event is determined, refund the costs to the Insured once he returns to the country of residence

3) In addition, if in case of treatment in a hospital, the Insured himself selects the hospital without consulting the Insurer, the Insurer has the right to refuse to directly compensate costs for hospital treatment to the healthcare institution, and to refund costs after the return of the Insured to the country of residence, in the manner defined by Article 10 of these Conditions (the Insurer) has the right to reduce the amount of compensation for damage resulting because the Insured did not fulfill his obligations defined by these conditions and the Insurance Contract)

4) If it is not possible to make an urgent phone call before consulting a doctor or going to the hospital, the Insured must show the Insurance Policy to the doctor or to hospital staff, who as a rule report the insured event by calling the on duty center of the Assisting Company

5) In any case, when for justified reasons, because of a sudden illness or accident, the Insured is not able to report the insured event, a report must be submitted within 48 hours from the occurrence of the insured event, and information must be supplied to the Assisting Company about the name and address of the hospital, name of the doctor treating the Insured, and relevant telephone numbers, otherwise the Insurer does not guarantee that treatment costs will be compensated

6) If the Insured is not able to report the insured event to the Assisting Company, a report submitted as soon as possible, but not after the deadline stated in the preceding Paragraph of this Article, by someone close, the police, a court body, the hospital institution or anyone who had come to the rescue, shall be valid as if the Insured had reported personally.

7) In case when, due to sudden illness or accident, the Insured is placed in a hospital for treatment (hospitalized), but due to an urgent serious health status, accompanied by altered consciousness is not able to make the report, in accordance with Paragraphs (5) and (6) of this Article, the Insurer shall recognize an additional deadline for reporting the insured event but not later then 7 days from the day of occurrence of the insured event and necessarily before leaving the hospital and before returning to the country of residence

8) For all reports made after the deadline defined in the preceding paragraphs of this Article provisions of Article 10 of these Conditions shall apply. In case if, due to objective reasons, the Insured does not report the case insured to the Assisting Company, but himself pays the costs of treatment, the Insurer will reimburse the Insured after the return to the country of residence, however to a maximum sum of 500 EUR

9) The liability claim must be submitted within three months following the finished medical treatment, or transport to the country of permanent residence, or in the event of death;

10) The Policy holder and the Insureds are obliged to give to the Insurer at its request all the information needed for the insured event assessment or for determination of the insurance cover scope

11) The Policy Holder or the Insureds authorize the Insurer to gather all information it needs from third parties (doctors, dentists, medical workers, medical institutions of all types, institutions of health insurance, health or care administrations). The Insured releases medical staff that had examined him before and after the occurrence of the insured event from the professional obligation of confidentiality, and agrees that the hospital or health care institution that had provided care may inform the Insurer or the Assisting Company about all required information pertaining to the health status of the Insured

Article 10. PAYMENT OF THE COMPENSATION

(1) Upon occurrence of an insured event, the Insurer is obliged to fulfill its obligation provided that besides the evidence of insurance cover also the requested evidence as stated in paragraphs from (2) to (4) of this Article has been presented

(2) The original Invoices with respect to the costs incurred must be presented to the Insurer. If duplicates of bills are presented, they must be certified by the institution that had issued the originals

(3) The bills must comprise the Insured's name, description of the disease, list of individual medical services with treatment details; the bill for medicines must clearly state the name of the medicine prescribed, its price, and contain the stamp of the pharmacy. In dental treatment, the bills must comprise a description of the teeth treated and of interventions performed on them

(4) The claim for payment of compensation for transport or funeral costs must be supported by bills. In case of death by an official death certificate and report of the competent person on the cause of death, a claim for compensation of the cost of patient's transport to the Republic of Serbia, with a medical certificate and description of the disease. In addition, the physician's certificate must prove the medical necessity of the return transport

(5) If, when concluding the Insurance Contract, the Insured gave false information about his age, and his actual age is over 65 years, the sum insured shall be reduced in proportion between the premium paid and the premium relevant for the actual age of the Insured

(6) If the Insured does not report the insured event to the Assisting Company , in accordance with Article 9 of these Conditions, but himself selects the healthcare institution, i e doctor, and pays treatment costs, the Insurer shall compensate the Insured for rational and usual costs defined by Article 6 after return to the country of residence, to the maximum amount of 500 EUR and provided that the claim is submitted within three months from the conclusion of treatment

(7) In case if the hospital or the doctor posses the Insured's original Policy, but fail to report the insured event to the Insurer within the deadline stated in Article 9 of these Conditions, and the Insured is discharged from the hospital or returns to the country of residence, the hospital, and/or the doctor, shall not be entitled to direct compensation by the Insurer and/or Assisting company for costs resulting in connection with the insured event.

(8) The compensation is calculated in RSD counter value according to the mean exchange rate of the National Bank of Serbia, as on the day of final settlement of compensation

Article 11. TERMINATION OF INSURANCE COVER

(1) The insurance cover terminates:
- at expiration of Insurance Policy validity, or
- at return to the Republic of Serbia, or
- at transport according to provisions of Point a) Paragraph (3) of Article 6

(2) Crossing of the border of the Republic of Serbia stands for the termination of stay abroad

(3) Should the medical treatment continue without interruptions even after expiration of Insurance Policy validity, insurance shall cover also the costs of such treatment, but not longer than 4 (four) weeks at the most, and under the condition that the ailing Insured could not have been transported to the Republic of Serbia, or if postponement was due to reasons beyond the control of the Insured.

Article 12. ASSIGNMENT OF RIGHTS OR SETTLEMENT OF CLAIMS

(1) Should the Policy Holder or the Insured assert indemnity claims against third persons on other grounds, that are covered by insurance, he must submit these claims in writing to the Insurer up to the amount of the insurance indemnity.

(2) Should the Policy Holder or the Insured waive such a claim, or his rights of claim assurance without the Insurer's consent, he shall lose the right of claiming the proportional part of the insurance indemnity.

(3) Should the Policy Holder or the Insured be indemnified by the person responsible for the damage, the Insurer is entitled to deduct the sum of this compensation from the insurance indemnity
If the Insured receives compensation from third parties regarding the insured event, the Insurer reserves the right to deduct such compensation from the compensation he is obliged to reimburse, in accordance with these Conditions

(4) The Policy Holder or the Insured may neither pawn nor assign his claims resulting from insurance

Article 13. PROTECTION OF PERSONAL DATA

(1) In line with the Personal Data Protection Act, the Policy Holder authorizes by his signature the use of personal data from the Application and the Enrolment Form, in collective data gathered, administered and maintained by the Insurer and its associated parties, authorized agencies and agents

(2) The Insurer shall process and exchange the data referred to in paragraph (1) of this Article with the Assisting Company with which it has a contract on business cooperation, in terms of these insurance policy conditions. The Insurer may communicate these data to the Reinsurer or the Coinsurer and/or other persons who by the nature of their work have access or process personal information in accordance with legal regulations

(3) The Insurer shall carefully preserve and process as a business secret all the data about the Insured applying all the data protection measures in accordance with legal regulations and internal regulations of the Company.

(4) The above stated personal data will only be used during the term of insurance for the purpose of informing the Policy Holder about the news and new offers of the Insurer.

Article 14. OUT-OF-COURT SETTLEMENT OF DISPUTES

(1) An appeal is permissible against decisions made by the Insurer. An appeal should be lodged at the branch of the Insurer where the insurance was concluded, either personally, by post, or via the Insurer's website

(2) Appeals are handled by the competent Appellate Commission in line with the Rules governing the internal appellate procedure in the Insurer. The decision of the Appellate Commission is final

Article 15. CONCLUDING PROVISIONS

(1) The relations between Insurer and Policy holders that are not governed by these General Terms and Conditions shall be governed by applicable legal provisions and the provisions of the Law on Obligations

(2) Any dispute arising from the relation between the Insured and/or Policyholder and the Insurer shall be settled solely by the relevant court that has subject matter jurisdiction with respect to the headquarters of the Insurer.