

**Chapter One**  
**GENERAL PROVISIONS**

**SECTION I. DEFINITIONS**

**Article 1.** The terms used in these General Terms and Conditions have the meanings defined below.

**1. The Insurance contract (insurance policy)** hereinafter referred to as „the Contract“ consists of these General Terms and Conditions, Special Terms and Conditions, and Addenda (if any). When the written document is meant, the contract is usually called “Policy”. The insurance contract contains detailed information about the insured individuals, the insurance year, the insurance premium, the deductible, and the beginning of the insurance.

**2. The Special Terms and Conditions (policy inventory)** are part of the Contract, containing the specific names, addresses, terms, dates, amounts, coverages, and conditions, as well as the signatures of the parties to the Contract.

**3. The Addendum** is an extraordinary part of the Contract, which contains amendments or additions to the Contract, as well as the signatures of the parties to the contract

**4. Parties to the contract** are the Insurer and the Policyholder

**5. Insurer** is Solely Owned Joint Stock Company (ZEAD) BULSTRAD LIFE VIENNA EAD with principal office and management address; Sofia, 6, Sveta Sofia St.

**6. Policyholder (client)** is the person, which concludes the Insurance contract with the Insurer and pays the contractual premium. If the health and/or the body integrity of the Policyholder are insured, then the Policyholder is the Insured.

**7. Insured** is the individual on whose health and/or physical integrity the insurance is concluded and to whom the incurred medical expenses are reimbursed and/or to whom the health goods and services are provided under these General Terms and Conditions, the Addenda thereto, and the insurance contract

**8. Group** is 10 or more individuals gathered according to a certain criterion different from their wish to be included in insurance. In the case of different insurance products that are variants of the present insurance, the parties to the contract may agree on a smaller number of individuals insured as a group.

**9. Third party - beneficiary** is the individual whom, upon the occurrence of circumstances stipulated in the contract, the insurance amount is paid. Under this insurance, beneficiaries may be relatives of the first or second line of the Insured. The beneficiaries are specified in the insurance contract.

**10. Family member** is a spouse, the individual with whom the insured individual lives in actual cohabitation, parents, children up to 18 years (or up to 25 years if they continue their education in secondary or higher education institutions), and grandchildren.

**11. Health package** is the combination of health goods and services regulated by type and scope, and provided to the Insured for restoration, protection, and improvement of his/her health, and covered by the Insurer under the General Terms and Conditions, the Addenda thereto, and the insurance contract. To financially secure the use of the health packages under this insurance, the Insurer uses two approaches, namely;

**11.1. Subscription service** - the Insurer financially secures the health services and goods purchased by the Policyholder only through the health service providers with whom the Insurer has signed contracts.

**11.2. Reimbursement of expenses** - the Insurer reimburses the expenses of the insured individuals incurred with a medical care provider freely chosen by the Insured according to the purchased health packages, limits of liability, and the percentage of reimbursement specified in the insurance contract.

**12. Insurance event** is an event occurring during the insurance period resulting in payment of insurance indemnity, where such event is due to a risk covered by this insurance.

**13. Covered risk** is the possible consequence of the occurrence of an insurance event determined in the terms and conditions of the insurance contract, upon the realization of which the Insurer must pay the insurance amount or a percentage of it.

**14. Insurance amount** is the amount that the parties agree to be paid by the Insurer to the Insured in fulfillment of the contract. The insurance amount under this insurance is the maximum amount of the Insurer's liability under the concluded insurance contract for securing the provided health services and goods and/or reimbursement of the medical expenses incurred for the health care of the insured during the contract period.

**15. Percentage of reimbursement** is the maximum amount of expenses for the specific type of health goods or services within the respective health package to be reimbursed by the Insurer.

**16. Insurance premium (hereinafter referred to as the „premium“)** is the amount which the Insurer demands against the liabilities of the Insurer under the Insurance contract.

**17. Insurance period** is the period for which the insurance contract is concluded. Its beginning and end are stated in the Special Terms and Conditions.

**18. Date of beginning of the insurance** is the day stated in the contract, from which the

insurance coverage thereof enters into force. If during the insurance period a new insured is added to the insurance coverage, the insurance coverage of that individual will enter into force on the date specified in the respective addendum.

**19. Date of ending of the insurance** is the day on which the insurance coverage under the contract ends. If during the insurance period an insured is excluded from the insurance coverage, the insurance coverage of that individual will end on the date agreed between the parties to the contract.

**20. Insurance coverage period** is the period for which the Insurer covers the risks under the insurance.

**21. Insurance period** is the period for which the insurance premium is determined. This term is one year unless a shorter or longer term is agreed. The insurance period may coincide with the term of the contract. It is also possible that the term of the insurance contract included more than one insurance period.

**22. Insurance year** is the part of the insurance period representing the time between the two anniversaries of the Contract. The anniversaries of the Contract are counted from the beginning of the insurance coverage.

**23. Date of annual renewal** is the date that is twelve months after the date of beginning specified in the policy.

**24. Accident** is an unexpected, random, and sudden event of origin external to the Insured, caused solely by violent, incidental external and visible means, and not by illness, disease, or gradual physical or mental process occurring during the insurance period against the will of the insured, which event has caused a bodily injury of the Insured (external or internal injury, broken or cracked bone, joint spraying, tearing or stretching of a tendon or a muscle, burning or frostbite of the body surface, poisoning, suffocation or drowning).

**25. Illness** is a combination of complaints and clinical manifestations diagnosed in a licensed health facility for the first time during the insurance term and registered in an official medical document. As a date of the occurrence of the illness, the date of its initial diagnosing is considered.

**26. General illness** is any illness according to the criteria of the World Health Organization, which is not defined as an occupational illness or traumatic injury.

**27. Acute disease** is a disease or illness with a sudden onset, severe symptoms, and short duration, including any intense symptoms such as severe pain.

**28. Pre-existing disease or condition** is an illness, bodily damage, medical condition, or symptom;

28.1. for which treatment or medications or consultations or consultations, or diagnosis have been sought or have been foreseen by the Insured before the beginning of the policy, or

28.2. whose origin precedes the beginning of the policy or has been known to the Insured before the beginning of the policy, whether or not treatment or medication, or consultations, or diagnosis have been sought or received.

**29. Chronic illness** is a disease or injury that has one or more of the following characteristics;

29.1. there is no known recognized treatment for it;

29.2. it continues indefinitely;

29.3. it recurs or is likely to recur;

29.4. it is permanent;

29.5. it requires palliative treatment;

29.6. it requires long-term monitoring, consultations, examinations, control examinations or tests;

29.7. the individual fighting it must be rehabilitated or specially trained.

**30. Congenital/hereditary diseases** are any hereditary disease, congenital disorder, physical abnormality, and/or any abnormality that has occurred after birth or a medical condition acquired during foetal development, whether or not diagnosed at the time. For insurance purposes, it is irrelevant whether the congenital disease is due to heredity or the environment. If the insurance contract is concluded with coverage for congenital/hereditary diseases, then the coverage is valid if all of the following conditions are met;

30.1. the mother has had maternity coverage under the insurance contract;

30.2. the child has been born during the validity of such maternity coverage;

30.3. within the first 30 days after its birth, the child has also been included in the group of insured individuals under the insurance contract;

30.4. under the contract, the insurance premium under this coverage is paid in full for the specific mother and child.

**31. Injury** means the partial or total loss of ability to work or live normally due to a bodily injury or health disorder caused by an accident or illness and confirmed by a qualified expert or by a specialized organization.

**32. Medical urgency** is a medical service or treatment which according to a qualified medical practitioner is appropriate and consistent with the diagnosis and which according to generally accepted medical standards could not be omitted without adversely affecting the condition of the insured individuals or the quality of the provided medical care. Urgent medical care is any disease or exacerbated chronic disease that has caused discomfort to the individual and is a prerequisite for seeking medical help.

**33. Emergency medical care** is a medical service or treatment of any patient who has a new or existing disease, where if medical activities are not undertaken immediately it can lead to death or irreversible morphological and functional damage to vital organs and systems.

**34. Hospital** is a medical facility for hospital treatment, established and licensed under the applicable Bulgarian law, where individuals with acute illnesses, traumas, acute chronic illnesses, and conditions requiring surgery in clinical conditions are treated in accordance with the medical standards established in the Republic of Bulgaria. Hospitals are not medical facilities for hospital treatment of individuals in need of long-term health recovery and individuals with chronic illnesses requiring care and maintenance of satisfactory physical and mental condition, as well as individuals requiring physical therapy, motor and psychic rehabilitation, balneology, climate- and thalassotherapy, as well as rehabilitation centres and specialized hospitals, clinics, and wards for the treatment of the mentally ill, alcoholics and drug addicts.

**35. Hospitalization (hospital stay, inpatient treatment)** is an uninterrupted minimum 24 (twenty-four) hour stay of the Insured in a hospital under physician prescription for the performance of the emergency test, monitoring, or treatment. Inpatient treatment cannot exceed 12 (twelve) months in total for each insurance event.

**36. Outpatient treatment** – the medical treatment of the Insured who is not a hospital patient. The outpatient medical care facilities are registered according to the Medical Facilities Act. They perform diagnosis, treatment, rehabilitation, and monitoring of patients; they monitor and provide medical care during pregnancy. The activity of the medical facilities and the medical and other specialists working there is carried out in observance of the medical standards for quality of the provided medical aid and ensuring the protection of the rights of the patient. The medical standards are approved by the ordinances of the Minister of Health.

**37. Physician** is a legally licensed medical practitioner recognized as a physician under the Bulgarian law and providing treatment covered by this insurance, and who during the providing of this treatment practices within the scope of his license and education.

**38. Specialized physician** is an individual duly qualified and legally licensed to practice medicine has a certificate for specialized education. The specialist must practice within the scope of his license and education.

**39. Physical and rehabilitation medicine** is a clinical medical specialty with a predominant therapeutic focus, which studies the biological impact of natural and preformed physical factors on the human body and applies them through therapy with physical factors or through medical rehabilitation. The treatment is prescribed by physicians specializing in „Physical and rehabilitation medicine“ and is carried out under their supervision. The expenses for physiotherapy do not include those for exercise before birth and during maternity, sports massages, and labour therapy.

**40. Rehabilitation centre** is a medical facility registered as such under the Bulgarian legislation (outside the hospitals, which are defined elsewhere) for treatment of individuals in need of long-term health recovery and individuals with chronic illnesses requiring care and maintenance of satisfactory physical and mental condition, as well as individuals requiring physical therapy, motor and psychic rehabilitation, balneology, climate- and thalassotherapy.

**41. Dentist** is a physician who is recognized as a dentist by a competent authority.

**42. Home care** is services in the home of the Insured prescribed by a physician due to medical (other than family) reasons and provided by a state-licensed nurse.

**43. Prescription medicines** are all end products that are substances or a combination of substances intended for the treatment of human diseases and used in their end packaging, as well as all substances or a combination of substances that are administered to humans for prophylaxis, diagnosis, or recovery, correction or modification of human physiological functions, but only the medicines that are prescribed by a physician and are in direct causal connection with the diagnosis and registered at the Executive Agency of Medicines. Within the meaning of these General Terms and Conditions, medicines are also generic medicines that are equivalent to the original pharmaceutical product and contain the same active substance.

**Ineligible for reimbursement are:**

43.1. recreation products and food supplements;

43.2. weight loss or weight control products, products against vegetative disturbances during travel, stimulants, anabolic hormones, and other doping type substances;

43.3. tonic products, medical wines, fish oil products;

43.4. laxatives;

43.5. cosmetic products, medical cosmetics;

43.6. baby foods and baby products other than those prescribed for a medical condition covered by the insurance;

43.7. contraceptives, except when used to treat a disease;

43.8. coloured lenses, computer spectacles, spectacle frames.

**44. Product level** is the option or the level of coverage of the insurance coverage selected as applicable by the Policyholder and specified in the insurance contract.

**45. Package service** is a service, which includes examinations and tests providing adequate care for the pregnant woman according to the medical standards.

**46. Indemnity limit** is the maximum amount due by the Insurer according to the applicable product level. This amount is deducted from the maximum insurance amount per Insured per insurance year. If the Insured exceeded his/her indemnity limit for any of his/her subscription coverages the Insurer has the right to deduct the exceeded amount from subsequent claims for reimbursement of expenses.

**47. Medical expenses** are all reasonable and necessary expenses incurred in connection with medical or surgical treatment of a medical condition provided by a specialized physician to whom the insured has been sent.

**48. Reasonable and usual costs** are the average amount calculated in connection with eligible expenses for services or treatment determined on the basis of the experience and practice of the Insurer, while the method of calculation is specified in Art. 16, Para. 2 of these General Terms and Conditions.

**49. Damage** - the total amount of expenses for treatment of each accident, bodily injury, or illness.

**50. Deductible** is the part of the expenses for which the Insured remains liable under the conditions specified in the insurance contract. The insured must pay the deductible related to each event leading to the filing of a damage claim, or the deductible is deducted from the due insurance amount.

**51. Deferral period** is the period specified in these General Terms and Conditions from the beginning of the insurance coverage for insurance events occurring during a period for which the Insurer does not owe payments.

**52. Waiting period** is the period specified in these General Terms and Conditions from the beginning of the insurance coverage for which the Insurer does not owe payments for occurring insurance events.

## SECTION II. SUBJECT

**Article 2.** These General Terms and Conditions are an integral part of the insurance contract and are the basis on which all claims for insurance payments will be considered. Each Insured must read them carefully to ensure that he/she fully understands all terms, exceptions, conditions, and restrictions.

**Article 3.** (1) The Insurance contract under this insurance is concluded against insurance risks related to the health, or the body integrity of the Insured, subject to the terms and conditions of the contract.

(2) The Insurer is obliged, against a paid insurance premium, upon the occurrence of an insurance event within the covered risk, to pay the insurance amount under the terms and conditions of the insurance policy.

**Article 4.** (1) „Healthcare“ insurance can be concluded for individuals aged from 18 (eighteen) to 70 (sixty) years. In the case of group insurance contracts concluded by an employer in favour of employees and workers, a higher maximum age may be agreed upon.

(2) The minimum age for insurance of another individual (family member) benefiting from the coverage of the insurance contract, is 0 (zero) years (after acquiring a Personal Identification Number), and the maximum age is 70 (seventy) years.

(3) The age of the Insured is determined in full years at the beginning of the insurance and the Insured must be not older than 71 (sixty-one) years by the expiry of the contract.

**Article 5.** This insurance can be concluded for individuals regardless of their health insurance status and citizenship.

**Article 6.** If within one month after the conclusion of the insurance policy under this insurance the Insured decided that it does not meet his/her needs, he/she has the right to terminate it with a written application submitted to the Insurer, provided that no insurance claims have been filed, while the premium is returned to the Insured less the part of it corresponding to the time during which the Insurer has borne the full risk.

**Article 7.** The territorial scope of the „Healthcare“ insurance is the territory of the Republic of Bulgaria.

## Chapter Two INSURANCE COVERAGE

**Article 8.** (1) The Insurer covers risks related to the financial provision of certain health services and goods against payment of an insurance premium.

(2) The insurer secures financially the performance of the health services and goods purchased by the Policyholder by concluding contracts with medical care providers - medical facilities, or by the free choice of a medical facility by the Insured.

**Article 9.** The health goods and services included in the scope of this insurance are described in Appendix 1 - „Covered risks under „Healthcare“ insurance“, which is an integral part of these General Terms and Conditions.

**Article 10.** (1) The health goods and services contained in Appendix 1 are grouped in six sections and three additional coverages to two of the sections, as follows;

1. Section I. „Prophylaxis“;

2. Section II. „Outpatient medical care“ with the following additional coverages;

2.1. Subsection „Pregnancy monitoring“;

- 2.2. Subsection „Extra Care“;
  3. Subsection III. „Hospital medical care“ with additional coverage „Birth“;
  4. Subsection IV. „Healthcare“;
  5. Subsection V. „Medicines, wound dressings, aids, and consumables“;
  6. Subsection VI. „Dental care“.
- (2) Appendix 1 describes the manner in which each of the services may be used - on a subscription basis or by reimbursement of expenses.
- (3) Depending on the type and scope of the health goods and services included in each section, the Policyholder has the right to choose between three options - Standard, Optimum, and Luxury.
- (4) During the validity of the insurance contract, the options selected upon the conclusion of the contract under Para. 3 cannot be changed unless explicitly otherwise agreed between the parties.
- (5) Section „Hospital medical care“ is used only as an upgrade of the basic package of the National Health Insurance Fund. The insurance amount under section „Hospital care“ does include the value of the clinical path covered by the National Health Insurance Fund, regardless of whether the Insured has been hospitalized under a clinical path or not. Under this section, the Insurer covers only the expenses explicitly agreed in the Special Terms and Conditions of the insurance contract.
- (6) If the services provided to the Insured under the „Hospital care“ section are not used under the procedure regulated by the National Health Insurance Fund the Insurer pays only the value of; choice of team/physician, medical consumables, and stay in a room with improved living conditions up to the amount agreed in the Special Terms and Conditions.
- Article 11.** If „Outpatient medical care“, „Hospital medical care“ and/or „Health care“ sections are purchased they can all be used in the form of subscription services and in the form of reimbursement of expenses, provided that there is a deductible. The requirement under the preceding sentence does not apply if a different way of using the packages listed in the insurance contract has not been agreed upon.
- Article 12.** (1) The additional coverage „Pregnancy monitoring“ to the „Outpatient medical care“ section includes additional services for the insured individuals above the volume under the „Maternal Health Care“ program of the National Health Insurance Fund. The volume of examinations and tests and their limit are specified in Appendix 1. When the Insured uses a package service the Insurer makes an insurance payment in the amount of the value of the package service paid by the Insured but not more than the limit specified in Appendix 1. To make an insurance payment for a package service, the Insured is obliged to present to the Insurer detailed written information from the medical facility about the number and types of examinations included in the paid package price.
- (2) The Insurer owes insurance payment under the „Pregnancy monitoring“ additional coverage after the expiration of the waiting period of 3 (three) months after entry into force of the insurance coverage of the Insured.
- (3) The „Extra Care“ additional coverage to section „Outpatient medical care“ is offered through a joint partnership with Diagnose.me and includes the provision of a second medical opinion by international health professionals provided through online consultations, as well as online consultation with a Bulgarian psychologist. This coverage can be used only on a subscription basis, while the access to the services included in this additional coverage is provided only through the B-Assist online platform.
- (4) The additional coverage „Birth“ to the „Hospital medical care“ section includes additional services for the insured individuals above the volume of the clinical paths for a birth of the National Health Insurance Fund. The volume of services and their limit are specified in Appendix 1.
- (5) The Insurer owes insurance payment under the „Birth“ additional coverage after the expiration of the waiting period of 6 (six) months after entry into force of the insurance coverage of the Insured.
- (6) Waiting or deferral periods, respectively, for the additional coverages „Pregnancy Monitoring“ and „Birth“ do not apply if the Insured has been insured under more than one insurance contract concluded with the Insurer, provided that there has been no interruption of the insurance period for the respective individual.

### Chapter Three INSURANCE COVERAGE EXCEPTIONS

**Article 13.** The exceptions in this chapter apply to absolutely all insurance risks covered by this insurance.

**Article 14.** (1) The insurance risks under this insurance, as well as the consequences thereof, are not covered in the cases where the insurance event is caused by or is due to:

1. medical treatment of a pre-existing disease or condition, as well as medical expenses arising from such, except in the cases of exacerbation of such disease or condition, which could lead to danger to life or serious deterioration of the bodily functions of the Insured, until the gathering of control of the critical situation, without subsequent medical treatment for improvement of the condition;
2. medical treatment for alcoholism, abuse/dependence on drugs, anabolics, stimulants, medicines, and other substances, or any state of addiction of any kind, and any injury or

disease arising directly or indirectly from such abuse or condition;

3. suicide or attempted suicide, any self-harm and unnecessary self-danger, except for the cases of attempt to save human life.
4. deliberate actions or fraud by the Insured, as well as the consequences thereof; deliberate exposure to danger and commission or attempt to commit a crime; deliberate damage to the own health; non-observance of a prescribed regime and/or treatment, simulation of illness by the Insured;
5. damages resulting from the involvement of the Insured in high-risk activities, for example (but not only) the following; motorsports, air sports, diving at a depth greater than 30 (thirty) meters, any sport involving animals, speed competitions, off-track skiing and any competitions (except walking). If a risky sport or activity is not explicitly mentioned in this list, the Insured must contact the Insurer to check whether this risk is covered under this insurance;
6. damages due to involvement of the Insured in military or terrorist actions, riots, etc., as well as when the damage has occurred while the Insured has been detained by authorities or is in prison;
7. care or medical treatment due directly or indirectly to the human immunodeficiency virus (HIV) or HIV-related diseases, including Acquired Immune Deficiency Syndrome (AIDS) or the AIDS-related complex (ARC) and any similar infections, diseases, injuries, or medical conditions due to such conditions, regardless of how they were caused;
8. cosmetic procedures or plastic surgery, as well as all health services used for cosmetic purposes; removal of fat or other excess body tissues and any consequences of such medical treatment, examinations and tests related to weight problems, whether or not weight gain or loss, eating disorders, whether or not due to psychological reasons; diagnosis and treatment of hair loss; diagnosis and treatment of acne; removal of lipomas, atheromas, and nevi without medical indications; sexual dysfunctions, including gender change;
9. experimental medical treatment or medical treatment without issued permits and the consequences thereof; involvement in activities or procedures for experimental and research purposes, as well as experimental and unproven medicine therapy;
10. medicines purchased without a physician's prescription, as well as routine or preventive medicines and examinations: treatment and tests performed without a physician's prescription; examinations and tests performed for prophylactic purposes;
11. all types of vaccinations and immunizations, as well as reactions related to them;
12. examinations without a diagnosis; prescribed examinations and therapies that do not correspond to the diagnosis;
13. transplantation, hemodialysis, and blood transfusion;
14. contraception, sterility, fertilization, vasectomy;
15. venereal diseases, sexually transmitted diseases, infertility and any related condition, form or preparation of assisted reproduction, examinations and tests related to reproductive problems;
16. air travel undertaken by an Insured whose pregnancy is at a stage after the 28th (twenty-eighth) week of gestation;
17. conditions resulting from injuries caused during childbirth, birth defects, diseases, or abnormalities lasting more than two months after birth;
18. medical treatment of mental, psychological, or neurasthenic disorders, including transient ones, depressive enduring of life events, nostalgia, psychiatric treatment, as well as expenses for psychotherapists, psychologists, family therapists, or consultants in the case of severe loss (except for the coverage in the luxury option of the „Healthcare“ section in both packages);
19. correction of farsightedness and myopia with laser procedures, which are of cosmetic and not medical nature;
20. laser surgery of the prostate gland;
21. PET scanner;
22. any type of treatment for which there are no approved medical standards or such that does not meet the approved standards;
23. diagnosis and treatment of sleep apnea, as well as all other sleep disorders;
24. medical treatment related to the taking, storage, or implantation of stem cells, whether own or donated;
25. medical treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, behavioural problems or problems related to the mental and physical development of the child;
26. termination of pregnancy (except in the case of miscarriage, ectopic pregnancy, or stillbirth);
27. medical treatment, which is a direct or indirect result of nuclear energy, hemodialysis, active radiation, nuclear explosions, natural disasters, and any other similar event with mass consequences. Exception for nuclear energy is not applicable when nuclear energy is used for medical treatment;
28. acupuncture, iris diagnostics, nutritionism, spa procedures, rehabilitation, and massages performed in specialized spa centres, sanatoriums, etc., which are not registered as medical facilities;
29. examinations and operative treatment of phimosis /circumcision/ except in the cases

when this is necessary for medical reasons.

(2) Except in the cases under Para. 1, the Insurer does not cover treatment and does not reimburse expenses for:

1. emergency medical care;
2. if the diagnosis and the treatment are covered by the Ministry of Health and/or the National Health Insurance Fund; or the treatment is under legally regulated insurance; a state scheme; subsidy agreement, other contract or health program;
3. expenses for examinations and tests related to the issuance of any medical certificates;
4. expenses for accommodation and treatment in hospices, old people's homes, hydro- or spa facilities, clinics for weight loss and/or for environmentally friendly life, health farms or other similar institutions, or in a medical facility, which has practically become a home or permanent residence of the Insured and his/her admission there is organized in whole or in part for family reasons;
5. expenses for purchased medicines, aids, and sanitary materials after the expiration of fifteen days from their prescribing, respectively six months for medicinal products prescribed on a prescription form for repeated use;
6. expenses for prescription spectacles/contact lenses after the expiration of three months from their prescribing. In cases where the Insured has been prescribed dioptre correction for only one eye the expenses for both glasses and contact lenses are covered;
7. expenses related to finding a donor organ, as well as any expenses incurred for the extraction of the donor organ and/or for the donor organ itself and/or the transport expenses for the delivery thereof, as well as all related administrative expenses;
8. expenses for implantation of an artificial heart;
9. any expenses incurred after the end of the insurance period unless the insurance contract has been renewed for another 12 (twelve) months, as well as any expenses incurred after the end of the insurance period during which the Insured has reached 71 (seventy-one) years;
10. any expenses incurred for emergency dental care due to food or drink (even if containing a foreign body), normal tooth wear, teeth brushing or any other oral hygiene procedure, or any reasons other than external impact, any form of restorative or corrective work, the use of precious metals, orthodontic treatment of any kind, implants and implant procedures, prostheses, splints, 3D diagnostics, dental physiotherapy, treatment of periodontitis or dental treatment carried out in a hospital unless the dental surgery is the only possible treatment to relieve pain;
11. expenses for liquid-based cytology coating ThinPrep, except for the cases for diagnosis of precancerous changes, after routine cytospin with indications of groups III or IV of PAP;
12. expenses for genetic tests, where molecular-genetic and biochemical-genetic diagnostics is defined as an analysis of DNA, RNA, genes, gene products (proteins and enzymes), and specific metabolites for detection of changes related to hereditary or acquired diseases. The analysis is performed through specialized diagnostic genetic tests - cytogenetic and molecular-cytogenetic test, molecular genetic test, biochemical genetic test;
13. expenses for diagnosing food allergies, inhalation test for allergies, as well as all types of atopy panels;
14. sclerotherapy and laser ablation (surgery) of superficial and deep veins, plasmapheresis, hyperbaric oxygenation;
15. expenses for medicines prescribed for the treatment of conditions related to pregnancy if the pregnancy is not a covered risk under the insurance contract;
16. expenses for medicines prescribed for dental treatment if the dental care is not a covered risk;
17. expenses for DNA prenatal test.

(3) If the contract concluded between the Insurer and a medical facility provides for co-financing of medical services provided under the contract, the Insurer does not reimburse services used by the Insured on a subscription basis in such medical facility that are at the expense of the Insured.

(4) When making insurance payments, the Insurer observes the normative regulation in the field of health care related to health underwriting, including the legally regulated limits of payments.

(5) Upon explicit written agreement between the parties and payment of an additional premium, some of the insurance coverage exceptions may be covered.

**Article 15.** (1) The Insurer does not pay and does not reimburse amounts determined legally as consumer fees, as well as any administrative fees and fees for issuance and/or receipt of documents, transcripts of documents, and any other type of information carriers required by medical facilities, or fees for translation of documents.

(2) The Insurer does not owe an insurance payment for the deductible of the Insured, specified in the insurance contract.

**Article 16.** (1) The Insured bears the responsibility for expenses, which after the deductible is applied (if such is agreed in the insurance contract) exceed the reasonable and usual expenses for the same service.

(2) "Reasonable and usual costs" within the meaning of Para. 1 means the average price of a given health product or service calculated as the arithmetic mean of the price

paid by SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD on a subscription principle for twelve consecutive months ending at the end of September of the previous year for all insurance claims for the same type of goods or services at the prices of medical facilities, opticians and pharmacies with which the Insurer has concluded contracts.

(3) Annually, at the beginning of January, updated information about the average prices of the most frequently used health goods and services is published on the website of the company.

## Chapter Four INSURANCE CONTRACT

### SECTION I. PRE-CONTRACTUAL INFORMATION

**Article 17.** (1) The insurance contract is drafted on the basis of an insurance application by the Policyholder, a list of the insured individuals, a health status declaration, the occupation, and the activity of the Insured, as well as other information that the Insurer may require to assess the insurance risk.

(2) If within 3 (three) months after signing the health status declaration, the occupation, and the activity of the Insured, the insurance contract is not concluded for objective reasons, a new declaration is required.

(3) Upon the conclusion of the Contract, the Policyholder/the Insured is obliged to announce the essential circumstances known to him/her that are essential for the risk. Essential are the circumstances for which the Insurer has put a written question. If the Policyholder/the Insured has declared inaccurately or has concealed a circumstance of such nature, the contract will be amended or terminated under the procedure specified in the Insurance Code.

(4) During the term of the contract, the Policyholder/the Insured is obliged to announce before the Insurer in written the new circumstances related to the occupation, the occupational duties, the activity, and the country of residence of the Insured, immediately after learning about such circumstances. In the case of non-compliance, the procedure specified in the Insurance Code applies.

### SECTION II. CONCLUSION, FORM, EFFECTIVENESS, AND AMENDMENTS OF THE INSURANCE CONTRACT

**Article 18.** The insurance contract is drafted by the Insurer after the Policyholder (the Insured) presents the required documents.

**Article 19.** (1) The insurance contract is concluded with healthy individuals at normal insurance risk.

(2) Individuals with higher insurance risk according to the criteria listed in the health status declaration are insured under terms and conditions determined in the insurance contract or an Appendix to the contract and against an additionally paid premium.

**Article 20.** (1) The insurance contract is concluded in written on the basis of a written application template of the Insurer accompanied by the following documents:

1. In the case of individual insurance and group insurance of a group consisting of less than 20 (twenty) individuals - health status declaration (according to the template of the Insurer);

2. In the case of group insurance of a group consisting of 20 (twenty) and more individuals – a list and a health status declaration only on demand by the Insurer.

3. In the case of insurance of family members wishing to join the insurance contract - health status declaration.

(2) In the cases under Para. 1, the contract may be concluded at the discretion of the Insurer without filling in a health status declaration.

(3) In the insurance application, the Policyholder indicates the selected sections and options for health goods and services, as well as the form of their provision.

(4) The insurance contract may contain simultaneously selected sections provided in the form of subscription service and such provided in the form of reimbursement of expenses.

(5) If a group insurance contract is concluded without application of the individual indemnity limit per Insured in the group specified in the respective option of the health package, an aggregate indemnity limit is applied for the whole group, for the amount specified in the contract.

**Article 21.** (1) Upon concluding a group insurance contract, the Policyholder is obliged to provide to the Insurer a list of the Insured individuals.

(2) The list under Para. 1 contains the following data: three names (written in Cyrillic), PIN, and the selected plan/product level for each individual. Where the Insured is a foreign citizen, it is obligatory to indicate the personal number of the foreigner (NRA), his/her gender, and date of birth. The list is a template of the Insurer and is Appendix 2, which is an integral part of these General Terms and Conditions.

(3) The Policyholder has the right to update the list of the insured individuals during the contract period by providing in writing to the Insurer the updated data.

(4) New insured individuals are included after written notification by the Policyholder and

the individual is included in the list under Para. 1.

(5) Inclusion of family members of insured individuals in a group insurance contract is carried out as follows:

1. Family members of the individuals included at the date of entry into force of the insurance contract may be added no later than two months after the entry into force of the contract;
2. Family members of the individuals included after the date of entry into force of the insurance contract may be added no later than one month after the date of the beginning of the insurance coverage of the respective individuals.
3. A newborn or adopted child during the insurance contract period may be insured within one month from the date of birth or adoption.
4. Family members - children under the age of 1 - are insured after submission of an epicrisis from birth, as well as a health status declaration.
5. The Insurer has the right to refuse insurance to individuals with high insurance risk, as well as to offer insurance under different terms and conditions, including a higher individual insurance premium.

(6) The Policyholder is obliged to explain to the insured individuals their rights and obligations under the contract, the medical care providers, the conditions and the procedure for receiving the health services and goods, as well as to hand them the identification cards according to the list and against their signature.

**Article 22.** (1) The Contract enters into force after the payment of the insurance premium unless agreed otherwise.

(2) The Insurer is obliged to provide the Policyholder/the Insured with an identification card and a list of medical care providers with which the Insurer has concluded contracts.

(3) The changes in the list of medical care providers with which the Insurer has concluded contracts are announced regularly on the website of the Insurer.

**Article 23.** (1) The Insured has the right to use personally the packages and options agreed in the insurance contract.

(2) Where the Insured has chosen the subscription service as a form of this insurance, he/she has the right to freely choose a physician and a medical facility on the territory of the whole country, with which the Insurer has concluded a contract. If the Insured has chosen the reimbursement of expenses as a form of this insurance, he/she has the right to freely choose a physician and a medical facility, regardless of whether the Insurer has concluded a contract with these.

**Article 24.** The expenses for health services and goods outside the ones agreed in the insurance contract, as well as those exceeding the indemnity limit under the concluded contract, are at the expense of the Insured.

**Article 25.** (1) At each visit to a physician or medical facility, the insured individuals identify themselves with an identity card and an identification card with a valid term of validity.

(2) In the case of loss or destruction of the identification card, the Insured informs the Insurer in order to be issued a copy. The Insured receives the copy against a declaration of invalidity of the lost/destroyed document.

**Article 26.** (1) The contract remains in force for a period of one year after the beginning date and is subject to renewal for subsequent one-year periods. (2) Where there is an interruption of the insurance coverage, the Insurer has the right to apply Art. 20, Para. 1, sub-section 1.

**Article 27.** (1) The Insurer has the right to change the amount of the insurance premium and/or the terms and conditions of the contract.

The Policyholder must be notified of the change and will be deemed to have given consent to this change unless he/she objects in writing to it within the period specified in the notification. In these circumstances, the insurance is terminated on the date specified in the notification by the Insurer.

(2) In the case of legislative changes or other changes of circumstances beyond the control of the Insurer, the consequences of which could not have been foreseen and which could lead to significant changes in the conditions for providing insurance protection, the Insurer may offer the Policyholder amendments in the tariffs and the terms and conditions of this insurance. The amendment enters into force upon the consent of the Policyholder. If there is no consent, the insurance coverage of the insurance contract is terminated and the Policyholder does not owe payment of insurance premiums under it from the date of the change.

(3) The amendment of the insurance contract is done by issuing an addendum, which enters into force at 24:00 hours on the date of its issuing unless agreed otherwise.

(4) The Insurer has the right to deduct from the policy payments any expenses incurred by it in connection with incorrect conduct by the Policyholder/the Insured.

**Article 28.** (1) The contract is terminated with the expiration of the insurance period.

(2) The contract may be terminated before the expiration of the insurance period in the following cases:

1. if the Insured has deliberately submitted false facts and circumstances;
2. upon reaching the age of 71 by an individual under Art. 4, Para. 2 of these General Terms and Conditions. In this case, the insurance coverage is terminated on the last day of the insurance year in which the Insured has reached this age;

3. by a unilateral statement by the Policyholder to the Insurer if the insurance interest has ceased during the term of the contract - within three months before the end of the insurance year, while the Insurer does not owe returning of insurance premiums;

4. for individual insurance contracts - with the death of the Insured, while in this case, the Insurer does not owe returning of insurance premiums;

5. if an instalment of the due insurance premium (including tax) by certain maturity date according to the agreed terms and conditions, is overdue by more than 15 (fifteen) days - under the procedure determined in the Insurance Code;

6. in other cases explicitly agreed under the insurance contract or provided by the Bulgarian law.

(3) Premature termination of the individual insurance coverage of the Insured under a group insurance contract enters into force on the day of returning his identification card to the Insurer. Until the day of returning the card, the Policyholder owes the insurance premium for the respective individual.

(4) In the cases where the insurance contract has been concluded by an employer and the insured individuals are its employees and/or workers and/or individuals under civil or management contracts, the Policyholder is obliged to take the identification card of the Insured in the day of termination of the legal relationship between them and return it to the Insurer. Otherwise, the Policyholder is liable for expenses incurred after the date of termination of the individual insurance coverage of the respective individual.

(5) If the contract is terminated prematurely due to default of the Policyholder, the Insurer does not owe returning of the unused premium for the remainder of the insurance period unless agreed otherwise.

(6) If during the insurance contract period the net quota of damage exceeds 150%, the Insurer has the right to propose an increase of the insurance premium. If the Policyholder does not accept the offer, the Insurer has the right to terminate the insurance contract prematurely. If the Policyholder has paid an insurance premium for a period after the date of termination, the Insurer must return it.

(7) In the case of premature termination of the contract, the insured individuals are obliged to return their identification cards to the Insurer as soon as possible. Any expense incurred by the Insured in the form of reimbursement of expenses after the end of his/her individual insurance coverage is not subject to payment by the Insurer.

**Article 29.** The Insurer has the right to refuse renewal of the insurance contract and to terminate or amend the terms and conditions of the contract if:

1. the Policyholder/the Insured commits or has committed fraud, concealment of facts, or false statements have been made. In this case, the Insured must return all amounts paid under the insurance contract.
2. the Policyholder/the Insured has breached the terms and conditions of the insurance contract.

**Article 30.** The possibility for termination of the insurance contract by the Policyholder does not apply if:

1. the change in the insurance premium and/or the other terms and conditions results from legal provisions;
2. the change leads to a reduction of the amount of the insurance premium and/or expansion of the insurance coverage.

**Article 31.** (1) The insurance payment is specified in the insurance contract.

(2) The insurance premium is paid once or annually. Upon explicit written agreement between the parties to the contract, the premium may be deferred.

(3) The insurance premium is paid upon the conclusion of the insurance contract for all insured individuals unless agreed otherwise.

(4) The Policyholder is obliged to pay the insurance premium or its instalments in the cases of deferred payment, in the amounts and terms specified in the insurance contract. If the Policyholder delays the payment of the premium or any instalment or pays less than the amount due, the Insurer may reduce the insurance amount, may amend the contract, or may terminate the contract under the procedure stipulated by the Insurance Code.

**Article 32.** (1) If the age of the Insured has been indicated incorrectly and as a result the paid insurance premium is insufficient, the Policyholder immediately owes additional payment of the difference in the premium.

(2) If the age of the Insured has been indicated incorrectly and as a result, the paid insurance premium is higher, the Insurer owes returning of the overpaid part of the premium without interest.

(3) If the age of the Insured has been indicated incorrectly and if due to his/her exact age the Insured would have not been entitled to coverage under this insurance, the Insurer does not owe insurance payments and its liability is limited to the returning of the total paid insurance premium without interest.

**Article 33.** (1) The Insurer prepares a health file of the Insured and keeps a register of the insured individuals containing the necessary information for their health status, the paid premiums and instalments, the used health services and goods, and the reimbursed expenses.

(2) Upon demand by the Insured, at the end of each insurance year the Insurer provides information about the health services and goods used by the Insured.

**Article 34.** The Insurer has the right to be informed about the health status of the Insured

and during the term of the insurance contract may carry out inspections through its own or independent experts, and may request additional information about the health status of the Insured from the medical service providers.

**Chapter Five**  
**RELATIONSHIPS IN THE CASE OF THE OCCURRENCE OF INSURANCE EVENT**

**Article 35.** (1) The Insured is obliged to submit all documents related to the identification of the event.

(2) If the submitted documents prove that the information for determining the insurance risk has been wrongly stated in the insurance application or that it has changed and the Insurer has not been informed by the Policyholder, the insurance amount or the part of it will be amended depending on the correct information and in accordance with the paid premium.

(3) The Insurer may refuse to pay the insurance amount or a percentage thereof if the Policyholder/the Insured has submitted untrue or altered evidence or documents.

**Article 36.** (1) In order to receive an insurance payment for reimbursement of expenses, i.e. where the expenses for treatment have been paid by the Insured, the Insured must submit the following documents (originals or certified copies):

1. application template of the Insurer;
2. medical form filled-in by the physician performing or/prescribing the treatment and/or the test;
3. prescriptions for the prescribed medicines or aids if they are not specifically recorded in a medical document (an ambulatory sheet or other document containing the same requisites);
4. invoices for the incurred expenses with entered separate items for each performed service (or a breakdown of the separate expenses attached to the invoice), together with the fiscal receipts to them, obligatorily in original;
5. epicrisis from the hospital;
6. description of the provided medical services;
7. for sanitary transport - documents certifying the need for such, issued by medical care providers;
8. for dental care - radiography, preceding treatment of pulpitis, periodontitis, and surgical services; an ambulatory sheet with entered performed activities. No radiography is required for children under 18 and pregnant women. The first filed claim related to dental care must be accompanied by a document certifying the full dental status of the Insured;
9. stickers for purchased prescription spectacles/contact lenses;
10. stickers for implanted medical devices or other evidence certifying the implanting of the medical device issued/provided by the same medical facility performing the surgery;
11. other documents confirming the date, cause, and circumstances of the occurrence of the insurance event or evidencing the incurred medical expenses.

(2) All claim templates must contain precisely listed and attached invoices and receipts with the following requisites:

1. patient name;
  2. printed invoice number;
  3. name and practice of the practicing medical specialist or medical facility;
  4. description of the provided services or products.
- (3) Each invoice for purchased medicines must be accompanied by the medical document with the prescribed medicines and/or the prescription for them and the receipt. The invoice must contain a description of the purchased medicines.

(4) The acquisition of all required documents, necessary for the determination of the basis and the amount of the insurance payment is at the expense of the Insured.

**Article 37.** In the case of death of the insured after receiving the health services, the Insurer reimburses the incurred medical expenses to the legal heirs of the Insured after submission of evidencing documents or to the respective medical facility, where the service has been provided.

**Article 38.** (1) The insurance payment is made within 15 (fifteen) days from the date of submission of all required documents to the Insurer.

(2) If in order to clarify the reasons and the circumstances of the occurrence of the insurance event, further evidence is needed, which was not provided for in the insurance contract upon its conclusion and which is necessary for establishing the grounds and the amount of the claim, the Insurer informs the Insured/the beneficiaries about the further evidence at latest within 45 (forty-five) days after the submission of the evidence determined in the insurance contract.

(3) In the case of partial or full refusal of insurance payment, the Insurer notifies the Insured about its reasons, while the notification may be made in one of the following ways: by regular mail, by e-mail, or by another means depending on in manner selected by the Insured for payment of insurance amounts.

**Article 39.** The Insurer makes insurance payments up to the indemnity limit specified in the insurance contract for each level of coverage of the respective Insured for insurance events occurring during the insurance period, for which reasonable and necessary expenses have been incurred.

**Article 40.** The Insurer is not liable for events occurring before the conclusion of the insurance contract, after its termination, and/or after the beginning or respectively the end of the individual insurance coverage of the Insured.

**Article 41.** (1) The Insured owes reimbursement of expenses incurred by the Insurer in the following cases:

1. if the Insured has not returned his/her identification card after the termination of his/her individual insurance coverage and has incurred expenses in medical facilities with which the Insurer has concluded contracts
  - owes the Insurer all amounts paid by the latter to the medical facility for the provided medical services after the termination of his/her individual insurance coverage;
2. if the Insured has exceeded his/her subscription service limit
  - owes the Insurer all amounts paid by the latter to the medical facility and exceeding his/her indemnity limit;
3. if in the form of subscription service the Insured has received treatment or health service representing an excluded risk under the insurance;
4. in any other cases of insurance payments other than those due by the Insurer and other than those agreed in the insurance contract and these General Terms and Conditions.

(2) The Insurer notifies the Insured in writing about the amount, the conditions, and the procedure for reimbursement of the amounts.

**Article 42.** (1) Where the subject of the insurance contract includes the „Prophylaxis“ option, the Policyholder prepares a preliminary application for conducting prophylactic examinations indicating the desired period for their performance, which covers not more than 90 (ninety) days and begins not earlier than 30 (thirty) calendar days from the date of receipt of the preliminary application by the Insurer.

(2) The preliminary application is submitted to the Insurer not later than 120 (one hundred and twenty) days before the end of the coverage under the insurance contract, while the application may be sent by regular mail, by e-mail, or by fax.

(3) The Insurer provides the Policyholder information about the minimum number of individuals who have to be registered for prophylactic examinations on the same day depending on the insurance coverage not later than 30 (thirty) days before the occurrence of the period under Para. 1.

(4) The Policyholder submits a final schedule with the desired dates for conducting prophylactic examinations of the insured individuals not later than 30 (thirty) days before the first desired date for prophylaxis. The schedule must contain specific dates, as well as explanations for the number and territorial location of the individuals if the individuals insured under the contract reside in more than one settlement.

(5) The Policyholder sends the Insurer nominal lists of the individuals subject to prophylactic examinations, as well as the dates of such examinations not later than 7 (seven) days before the beginning of the prophylactic examinations, according to the final schedule under Para. 4.

(6) The Insurer organizes additional (reserve) dates for prophylactic examinations for the individuals who for objective reasons could not pass the examinations on the main dates. The number of additional (reserve) dates is determined by the Insurer and depends on the number of insured individuals and the insurance coverage.

(7) The Policyholder is obliged to notify and organize the insured individuals to conduct the prophylactic examinations according to the final schedule presented to the Insurer.

(8) If the insured individuals do not appear for prophylactic examinations on the main dates determined according to the schedule and on the organized reserve date, the obligation of the Insurer to organize and conduct prophylactic examinations is considered fulfilled.

(9) The Insurer does not reimburse insurance premiums to the Policyholder and does not transfer insurance premiums to the next insurance period in the case of refusal of the Insured to appear for prophylaxis organized according to the terms and conditions of the contract.

**Chapter Six**  
**ADDITIONAL PROVISIONS**

**SECTION I. PERSONAL DATA PROTECTION**

**Article 43.** (1) The Insurer in its capacity of a data controller protects the personal data in accordance with the requirements of Regulation (EU) 2016/679 of the European Parliament, the Personal Data Protection Act, and the Internal Rules and Policies of the Insurer. The provided personal data are used by the Insurer for the purposes of concluding, administration, fulfilling of obligations, and settlement of claims under insurance contracts. Information about the purposes and the terms for processing of personal data is published on the official website of the Insurer at [www.bulstradlife.bg](http://www.bulstradlife.bg).

(2) When concluding insurance contracts under this insurance, as well as during the contract period, the Insurer is entitled to receive detailed and accurate information regarding the following categories of personal data: name, PIN, age, gender, health status of the individual whose life, health or physical integrity are subject to insurance.

(3) Upon the occurrence of an insurance event, the Insurer has the right of access to

personal data contained in all medical records related to the health status of the individual whose life, health, and bodily integrity are insured by the Insurer, and may require it from all persons keeping such information, including under the Medical Facilities Act, the Health Insurance Act and the Health Act for the purpose of fulfilling its obligations under the insurance contract.

- (4) The Insurer is not entitled, without the consent of the concerned individual to disclose to third parties any known personal data except in the cases provided by the law in accordance with the agreement between the parties, or for prevention of insurance frauds.
- (5) The provision of personal data is entirely voluntary. The refusal to provide personal data is grounds for the Insurer to refuse to conclude a contract or to act otherwise if the absence of such data does not enable objective assessment of the risk of the transaction or otherwise endangers the realization of the legitimate interests of the Insurer.
- (6) Any data subject has the right of access to them and is free to exercise his/her rights under the applicable personal data protection law and the Internal Rules of the Insurer.

**SECTION II. LEGAL, ECONOMIC AND TRADE SANCTIONS**

**Article 44.** Provided that this does not violate any regulation or specific national law applicable to the Insurer and notwithstanding the conditions of this insurance contract, the Insurer shall not be deemed to provide cover or be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer to trade, financial or economic sanctions, embargoes, laws or regulations which are applicable by the Insurer. Applicable trade, financial or economic sanctions and embargoes may be as follows:

- a) national sanctions;
- b) sanctions of the European Union (EU);
- c) sanctions of the United Nations (UN);
- d) sanctions of the United States of America (USA);
- e) sanctions of the United Kingdom (UK).
- f) other sanctions.

**SECTION III. GENERAL PROVISIONS**

**Article 45.** In the case of illness or accident, the Insured is obliged to assist in the fastest possible recovery and for any medical examinations requested by the Insurer or for any monitoring in a hospital requested by the Insurer, all at the expense of the Insurer.

**Article 46.** As soon as an insurance event occurs, the Insured must make every effort to mitigate its effects.

**Article 47.** The Insurer has the right through its medical representatives to examine each Insured whenever and as often as reasonably possible within the time limit for ruling on the application for insurance payment submitted by the Insured.

**Article 48.** (1) All notifications for which the law requires an official written form and which must be addressed to the Policyholder or the Insured are sent to the last address communicated by the Policyholder or the Insured in writing to the Insurer. The obligation of notification of the Insurer is considered fulfilled if it has sent the notification to the last known address of the Policyholder/the Insured.

(2) The notifications to the Insurer for which the law requires an official written form must be sent/deposited in writing to the address of management of the Insurer.

(3) All notifications for which the law requires an official written form may also be exchanged by e-mail if the Insured has requested so and has indicated a valid e-mail address.

(4) As a date of the notification, the date of the receiving of the notification is considered. This rule does not apply when the Policyholder has not notified the Insurer about the changes in his/her current mailing address, or the insured has not notified the Insurer about the changes in his/her current mailing address or e-mail address. In this case as a date of the notification the outgoing date of the notification is deemed.

**Article 49.** In the case of loss or destruction of the policy, the Policyholder must notify the Insurer immediately in order to obtain a certified copy thereof. The Policyholder receives the copy against a declaration of invalidity of the lost/destroyed copy.

**Article 50.** If the coverages under an insurance contract concluded under this insurance are also covered by another insurance contract(s) concluded on an earlier date, the insurance contract covers only the excess over the coverage provided by the other

insurance contract(s).

**Article 51.** (1) If the Policyholder/the Insured has questions or complaints, he/she may contact the Insurer at the address specified in the insurance contract.

(2) The Insurer reviews the complaint as soon as possible and responds to the complainant according to the terms and conditions of the rules of the Insurer.

(3) The procedure for lodging complaints at the Insurer is published on the website of the Insurer at [www.bulstradlife.bg](http://www.bulstradlife.bg).

**Article 52.** (1) According to these General Terms and Conditions, the following information is considered confidential:

- 1. the amount of the insurance premium paid under the insurance contract, as well as the Special Terms and Conditions of insurance agreed between the parties (if any);
- 2. the personal data processed under the insurance contract;
- 3. other data recognized as confidential according to the applicable laws and/or the common sense and the common commercial practice.

(2) Except for the exceptions provided for in the insurance contract, the Insurer, the Policyholder, the Insured, and the dependent individuals must take sufficient measures to prevent the disclosure of confidential information to unauthorized third parties.

**Article 53.** The rights under the insurance contract lapse with the expiration of the period determined by the Bulgarian law.

**Article 54.** (1) These General Terms and Conditions are an integral part of the insurance contract and must be considered together to avoid misunderstandings.

(2) Advertising materials or information brochures are not part of the insurance contract.

**Article 55.** (1) The insurance contracts issued under the present General Terms and Conditions are subject to the legislation and the law of the Republic of Bulgaria;

(2) The disputes between the parties are resolved by mutual agreement and, where impossible – before the competent Bulgarian court. The applicable law is the Bulgarian law.

**Article 56.** (1) All taxes, fees, etc. existing or pending to be imposed upon the received insurance payment are at the expense of the beneficiaries of the insurance payment, the Insured, or their heirs.

(2) The Insurer is not liable for the consequences of possible changes in the tax legislation applicable to the Policyholder or the Insured.

**Article 57.** The Insurer is not liable for failure or delay of the fulfilment of its obligations under the insurance contract caused or arising from circumstances beyond its control, i.e. force majeure circumstances, including (but not limited to): events that are unforeseeable, unpredictable, or unavoidable (such as extremely bad weather, floods, earthquakes, storms, thunderstorms, fire, landslides, epidemics, pandemics, terrorist attacks) hostile actions (whether war is declared or not), riots, explosions, etc., strikes or other labour unrest, civil unrest, sabotage, disorganization of government or financial authorities, telecommunications networks or money transfer systems failure, and any other actions or events beyond the reasonable control of the Insurer). For the avoidance of doubt, the Insurer is released from its obligations under the insurance contract if the fulfilment of such obligations becomes impossible as a result of international sanctions.

**Article 58.** Subsequent amendments and appendices to these General Terms and Conditions enter into force only for insurance contracts concluded after the date of the amendment and do not affect the existing contracts unless a change in regulation requires it or the parties agree otherwise.

**FINAL PROVISIONS**

§1. These General Terms and Conditions have been amended and supplemented by a decision under MoM No. 104 of 27.02.2013 amended and supplemented by MoM No. 147 of 10.12.2014 of a meeting of the Management Board of ZAD BULSTRAD LIFE VIENNA INSURANCE GROUP AD, amended and supplemented by a decision under MoM No. 304 of 10.03.2021 and MoM No. 338/09.06.2022 of a meeting of The Management Board of SOLELY OWNED JOINT STOCK COMPANY (ZEAD) BULSTRAD LIFE VIENNA INSURANCE GROUP EAD.

§2. An integral part of these General Terms and Conditions is Appendix 1 - „Covered risks under „Healthcare“ insurance and Appendix 2 – „Template of a list of insured individuals“.

This document is prepared and adopted in Bulgarian, and the current version is its translation into English. In case of any discrepancy between the English and Bulgarian versions, the Bulgarian text shall prevail.

The Policyholder declares that he/she is acquainted with these General Terms and Conditions, accepts them, and will acquaint all insured individuals with them.

Policyholder: .....  
(name of the company, UIC)

Represented by : ..... Signature: ..... Date: .....  
(name, surname, family)