Offer No. 2 of 14.08.2021 for the conclusion of the Agreement of voluntary insurance of medical expenses related to COVID-19 disease for foreigners and stateless persons

This Offer contains the "Proposal and Procedure for Conclusion in Electronic Form" of the Agreement of voluntary insurance of medical expenses related to COVID-19 disease for foreigners and stateless persons, hereinafter referred to as the Agreement, and proposed by the Private Joint Stock Company "INSURANCE COMPANY "INTER-PLUS" (hereinafter - the Insurer, PJSC "IC " INTER-PLUS ") "General Conditions of Insurance", which constitute Part B of the Agreement (if the latter is concluded), hereinafter - the General Conditions.

This Offer concerns the conclusion of the Agreement in electronic form. The Offer is valid from 14.08.2021.

If the Policyholder accepts the Offer, insurance is carried out in accordance with Part B of the Agreement, which is an integral part of this Offer.

1. Proposal and procedure for concluding the Agreement in electronic form

1.1. The Client (potential Policyholder), when filling out an electronic application form received on the Insurer's website **https://www.inter-plus.com.ua**, or using the "cloud" Internet service, provides the Insurer with the information necessary to identify the Policyholder, calculate the amount of Insurance Premium and form Part A of the Agreement "Special Conditions of Insurance", hereinafter - the Special Conditions. An application filled out in this way, if properly executed, is equivalent to a written application of the Client (potential Policyholder) to conclude the Agreement.

1.2. On the basis of the filled out Application, the Insurer calculates the Insurance Premium and generates the file "Special Conditions" - Part A of the Agreement, which is offered to the Client (potential Policyholder) by sending the corresponding file to the Client's email address specified in the Application.

1.3. The unconditional acceptance by the Client of the terms of the Offer and consent to conclude the Agreement is the provision of the Client's response to the Insurer on the acceptance of the Offer and signing the Agreement - by using an electronic signature with a one-time identifier OTP (One Time Password) - an alphanumeric sequence that the Client receives via SMS (Viber)-message to a mobile phone number, which is indicated by the Client when filling out personal data in the Application file.

1.4. By affixing a signature with a one-time identifier specified in clause 1.3 of this section of the Offer, the Client (Policyholder) confirms that he/she:

1.4.1. prior to the conclusion of the Agreement, is familiar with the content of Part 2 of Article 12 of the Law of Ukraine "On Financial Services and State Regulation of Financial Services Markets";

1.4.2. understands the essence of financial services provided by the Insurer under the Agreement;

1.4.3. gives consent to the Insurer for the processing of his/her personal data, including: those that relate to the state of health, and for transfer of such personal data to counterparties, including non-residents, in order to fulfill the terms of the Agreement;

1.4.4. has read and agree with the insurance terms and conditions set out in Parts A and B of the Agreement;

1.4.5. is familiar with the original signature of the authorized person and the seal of the Insurer specified in clause 1.9 of this section of the Offer, and deliberately agreed to sign the Agreement on his/her part by affixing an electronic signature with a one-time identifier;

1.4.6. agrees to receive the Agreement in electronic form and other commercial electronic messages of the Insurer to his/her personal e-mail specified in the Application when entering personal information;

1.4.7. agrees to pay the Insurance Premium on the terms and conditions stipulated by the Agreement.

1.5. After the acceptance of the Offer:

The Policyholder pays the amount of the Insurance Premium specified in Part A "Special Conditions" of the Agreement in a non-cash form to the account of the Insurer.

After payment of the insurance payment, the Client acquires the status of the Insured and receives at the e-mail address specified when filling out the Application, the Insurer's notification confirming the conclusion of the Agreement in electronic form by sending an electronic document - visual form of Part A of the Agreement.

1.6. The implementation of these actions is the conclusion of the Agreement in electronic form, which, in accordance with paragraph 12 of Article 11 of the Law of Ukraine "On Electronic Commerce", is equivalent to the written form of an agreement.

1.7. The Agreement is considered signed by the Insurer in accordance with Article 12 of the Law of Ukraine "On Electronic Commerce", if on the visual form of Part 1 of the Agreement and in the Offer there is an analogue of the handwritten signature of the authorized person of the Insurer and the seal of the Insurer.

1.8. The Parties to the Agreement undertake the obligation to recreate the Agreement in hard copy, if necessary. At the written request of one of the Parties to conclude the Agreement in writing, such an Agreement is made within 5 (five) working days from the receipt of the relevant request and is subject to signing and affixing a seal (if any) by each of the Parties within 5 (five) working days from the date of its making. If one of the Parties refuses to sign the Agreement, the dispute is subject to judicial review in accordance with the current legislation of Ukraine.

1.9. A sample of the signature of the authorized person of the Insurer and the seal of the Insurer are given below:

Deputy of the
Chairman of the Board
PJSC "IC "INTER-PLUS"
Bonkovska I.V.

1.10. The date, time, procedure for accepting the Offer, a message confirming the conclusion of the Agreement in electronic form and making payment, exchange of electronic messages between the Parties, information about the fact of making the Agreement in writing are stored in the electronic database of the Insurer.

1.11. Making changes to the Agreement, as well as its early termination, are carried out on the basis of an application submitted by one Party to another Party in writing or in electronic form, by sending it to email address of the relevant Party.

PJSC "IC " INTER-PLUS ",
04116, city of Kyiv, street Starokyivska, build. 8/12 Tel. (044) 394-54-22 email address:: info@inter-plus.com.ua

2. AGREEMENT OF VOLUNTARY INSURANCE OF MEDICAL EXPENSES RELATED TO COVID-19 DISEASE FOR FOREIGNERS AND STATELESS PERSONS

PART B. GENERAL CONDITIONS OF INSURANCE

1. SUBJECT OF THE AGREEMENT

1.1. The subject of the Insurance Agreement is property interests that do not contradict the law, related to the life, health of the Insured Persons and medical expenses of the Insured Persons, which occurred as a result of a health disorder associated with COVID-19 disease at the time of the Insured Person's travel (trip) to Ukraine.

1.2. Under this Agreement, the Insurer undertakes, upon the occurrence of the Insured Event, to pay the Insurance Claim, and the Policyholder undertakes to pay Insurance Premiums within a certain time frame and comply with other conditions of this Agreement.

2. TERMS USED IN THE AGREEMENT

2.1. **COVID-19** is the abbreviated name for the disease caused by the SARS-CoV-2 coronavirus. The MKX10 code for this disease is "U07.1"

2.2. **SARS-CoV-2** is a single-stranded RNA-containing strain of the SARS-CoV type of coronavirus of the Betacoronavirus genus, which causes COVID-19 disease.

2.3. **Assistance -** a legal entity acting on behalf of and on behalf of the Insurer and coordinating the actions of the Insured (Insured Person) and persons providing services to the Insured Person in the event of an insured event.

2.4. **Insurance Agreement (Agreement)** is an Agreement of voluntary insurance for medical expenses. The Parties to the Agreement are the Insurer and the Policyholder.

2.5. **Insured Person** is an individual - a foreigner or a stateless person, in whose favor the Agreement is concluded and who is temporarily on the territory of Ukraine on a legal basis.

NOTE. Foreigners and stateless persons permanently residing in the territory of Ukraine, persons recognized as refugees or persons who need additional protection cannot be the Insured Persons. If this Agreement is concluded with respect to such persons, it is considered concluded under the influence of delusion and does not contain legal consequences for the Insurer, except for the obligation to return in full the erroneously paid Insurance Premium.

2.6. **Competent authorities:**

2.6.1. state bodies, whose competence includes elimination of the consequences of the Insured Events, establishing the causes and circumstances of the occurrence of the Insured Events, assessing their consequences, as well as providing official clarifications on issues related to the circumstances of the Insured Event;

2.6.2. legal entities with appropriate powers, to which the Insurer or the Policyholder can apply to resolve disputes and other issues arising from the Agreement.

NOTE. The competent authorities, in particular, are considered: law enforcement agencies, medical institutions, courts and the like.

2.7. **Country of permanent residence** is a country in which the Insured Person resides for a total of at least 183 (one hundred eighty-three) days in a calendar year.

2.8. **Limit of Insurance Claims (Limit)** is the maximum amount of obligations of the Insurer, established under this Agreement, in terms of individual elements of medical assistance provided to the Insured Person in case of the Insured Event.

2.9. **Medical assistance** is the activity of professionally trained medical workers aimed at diagnosing and treating the Insured Persons in connection with COVID-19 disease. Within the framework of the Agreement, the services of state/communal medical institutions are paid.

2.9.1. **Urgent care** is medical care, which includes implementation of urgent organizational, diagnostic and therapeutic measures by emergency medical care workers aimed at saving and preserving the life of a person with COVID-19 disease who is in an emergency condition and minimizing the consequences of such a condition for his/her health.

Scope of urgent services:

1) round-the-clock reception by the Assistance of requests for the provision of emergency assistance to the Insured Persons;

2) visit by the emergency medical team of the Insured Person's location;

3) measuring the saturation of capillary blood with oxygen, taking an ECG, measuring blood pressure, counting heart rate and respiration rate, conducting laboratory tests establishing a preliminary diagnosis;

4) provision of medicines for emergency care at the pre-hospital stage;

5) medical manipulations (injections, resuscitation measures, oxygen therapy and other qualified medical care);

6) transportation by an emergency medical car to a state/communal health facility closest to the place.

2.9.2. **Emergency inpatient care** - medical care provided to the Insured Person in a 24-hour hospital (SIMI), if the Insured Person has COVID-19 with a severe course of the disease and meets the criteria for hospitalization in conditions of the Insured Person, when the absence of immediate medical intervention can lead to serious (including persistent) dysfunctions of the body, or to a threat to the life of the Insured Person. In this case, the "Medical card of an inpatient" indicates "Hospitalized for urgent reasons."

Scope of emergency inpatient care services during stay at the SIMI:

1) consultations and other professional services of medical personnel, incl. doctors of narrow specialization - both in the main disease and in concomitant diseases that affect the course of the underlying disease;

2) diagnostic tests: laboratory (general clinical, biochemical, bacteriological, etc. (except for the PCR test for SARS-CoV-2) and instrumental (ultrasound, bronchoscopy, ECG, RG - by doctor's prescription;

3) medical manipulations (injections, catheterization, etc.);

4) drug treatment, incl. resuscitation measures, anesthetic management (anesthesia);

5) stay in wards, standard for medical facilities, incl. in the intensive care unit;

6) catering, standard for medical facilities.

The duration of treatment in SSMZ is not more than 14 (fourteen) continuous calendar days. From the date of hospitalization.

2.10. **Medical service** is a service provided to a patient by a healthcare institution and paid for by the customer.

2.11. **Place of validity the Agreement** is the territory of Ukraine, except for the temporarily occupied territories and settlements, on the territory of which state authorities temporarily do not exercise their powers, and the list of settlements located on the line of contact in the zone of the JFO (joint force operations) and determined in accordance with the current legislation of Ukraine.

2.12. **Order 722** is the Order of the Ministry of Health No. 722 of 28.03.2020 "Organization of medical care for patients with coronavirus disease (COVID-19)", which approved the Standards of medical care "Coronavirus disease (COVID-19)", with amendments and additions.

2.13. **Observation facility** is a specialized institution intended for the temporary stay of persons subject to observation, their examination and medical supervision over them.

2.14. **Observation** is the stay of a person with respect to whom there is a risk of spreading an infectious disease in a specialized institution (the Observation facility) for the purpose of examining such a person and carrying out medical supervision over him/her.

2.15. **Course of the disease** is a set of symptoms of COVID-19, which characterizes the course of the disease in a particular person.

2.15.1. **Mild course of the disease** is characterized by:

low fever (up to 38 ° C), well controlled by taking antipyretic drugs; runny nose; dry cough without signs of respiratory distress (such as difficulty breathing, increased respiratory rate, hemoptysis); lack of gastrointestinal manifestations (nausea, vomiting and / or diarrhea); lack of changes in mental state (impaired consciousness, lethargy).

2.15.2. **Severe course of the disease** is characterized by:

signs of pneumonia and / or respiratory failure (an increase in the respiratory rate above 30 per minute, an increase in heart rate above 130 per minute, a decrease in systolic blood pressure below 90 mm Hg, hemoptysis, SpO2 when measured with pulse oximeter <92%) in the presence of radiologically confirmed pneumonia, the presence of clinical and instrumental data of acute respiratory distress syndrome (ARDS), the presence of clinical and laboratory data of sepsis and / or septic shock (systemic inflammatory response syndrome); the presence of clinical and laboratory signs of organ / systemic failure, except for respiratory.

2.15.2.1. Regardless of the severity of the condition, the laboratory-confirmed PCR diagnosis of COVID-19 in patients who belong to the following risk groups for complications is equated to a **severe** course of the disease: severe arterial hypertension, decompensated diabetes mellitus, immunosuppressive conditions, severe chronic pathology of the respiratory and cardiovascular vascular systems, renal failure, hyperthermic syndrome, which is difficult to correct (a temporary, no more than 1 - 1.5 hour decrease on the background of taking antipyretic drugs, followed by an increase).

2.16. **PCR** means a polymerase chain reaction.

2.17. **Rules** means “Rules for voluntary insurance of medical expenses” of the Insurer - CJSC IC “INTER-PLUS”, registered in accordance with the established procedure.

2.18. **Medical emergency** is a sudden deterioration in a person's physical health that carries direct and inevitable threat to the life and health of a person and arises due to reasons corresponding to the symptoms of COVID-19 disease.

2.19. **Parties to the Agreement (Parties)** is the joint name of the Insurer and the Policyholder/ Insured Person in this Agreement.

2.20. **Insurance Act** is a document that is drawn up by the Insurer to confirm the occurrence of the Insured Event and is the basis for making the Insurance Claim. The Insurance Act is drawn up on the basis of documents on the medical services provided to the Insured Person.

2.21. **Insured Event** is an event stipulated by the Agreement, which took place and with the occurrence of which the Insurer becomes obliged to pay the Insurance Claim.

2.22. **Insurance Claim** is the amount of money paid by the Insurer in accordance with the terms of the Agreement upon the occurrence of the Insured Event.

2.23. **Insurance Premium** is the payment for insurance that the Policyholder is obliged to pay to the Insurer in accordance with the Agreement.

2.24. **Insured Sum** is the amount of money within which the Insurer, in accordance with the terms of the Agreement, is obliged to pay the Insurance Claim upon the occurrence of the Insured Event.

2.25. **Insured Risk** is an expected event, for which insurance is carried out and which has signs of probability and accident of occurrence.

2.26. **Insurance rate** is the rate of the Insurance Premium per unit of the Insured Sum for a certain period of insurance.

2.27. **SIMI** is a specialized state/communal inpatient medical institution in which individuals are hospitalized in case of COVID-19 disease, if the criteria for hospitalization provided for by the Order 722 and other current regulations of the Ministry of Health of Ukraine are met.

2.28. **SARS** is a severe acute respiratory syndrome.

2.29. **Third Party** is any legal entity or individual, except for the Insurer, Insured Person.

3. INSURED RISK. INSURED EVENT

3.1. The insurance risk is a certain event related to the Insured Person's illness with COVID-19 at the time and place specified in this Agreement.

3.2. The insured event is the implementation of documented costs for the Insured to receive Emergency Medical Care and Emergency Medical Care in the amount, time and place specified in the terms of the Insurance Contract, due to severe COVID-19. The event is recognized as an insured event subject to laboratory confirmation of COVID-19 by the Insured by means of a PCR test. Insurance coverage covers only the severe course of the disease on COVID-19, as well as the services of the Observation - during the stay of the Insured Person in the institution designated by the local authorities as the Observer, only during the insurance coverage of the contract.

3.2.1. In case of the Insured Event according to clause 3.2 of the Agreement, the Insurer reimburses the costs for:

3.2.2. provision of the Insured Person with urgent assistance;

3.2.3. provision of the Insured Person with emergency inpatient care.

3.2.4. expenses for the Insured Person during his/her stay at the Observation facility/hotel. At that, expenses within 300 UAH per day for a period not exceeding 14 (fourteen) days are subject to reimbursement. The insurer is liable only during the insurance coverage of the contract.

4. RESTRICTION OF INSURANCE. EXCLUSION FROM INSURED EVENTS

4.1. Under this Agreement may not be insured persons who at the time of the Agreement:

4.1.1. declared incapable in the prescribed manner; are disabled of the I or II or III group; are HIV-infected; are registered in oncological, narcological, psychoneurological, tuberculosis, dermatological and venereological dispensaries, centers for prevention and control of AIDS;

4.1.2. who had a history of acute cerebrovascular accident (stroke), myocardial infarction, spinal cord and spinal cord injury, brain or spinal cord tumors, spinal cord, brain death, nervous system lesions in malignant neoplasms, acute encephalitis, mental illness , alcoholism, drug addiction, oncological diseases, oncohematological diseases;

4.1.3. The insurance contract is not concluded for persons under 18 years of age and persons over 65 years of age.

4.2. The Event that occurred as a result of COVID-19 disease in the Insured Person, which took place outside the terms and the Place of Validity of this Agreement is not recognized the Insured Event.

4.3. The Insurer is released from the obligation to pay the Insurance Claims in the following cases:

4.3.1. Receipt of a claim for reimbursement of costs for testing the Insured Person for COVID-19;

4.3.2. Receipt of a claim for reimbursement of costs and for conduction of a computed tomography of the thoracic organs, except for 1 (one) CT examination when providing emergency inpatient care to the Insured Person, if the Insured Person has a positive laboratory confirmed diagnosis of COVID-19 disease;

4.3.3. Receipt of a claim for reimbursement of costs for observation of the Insured Person, in the absence of appropriate recommendations from the competent authorities about the presence of such the Insured Person in the Observation facility;

4.3.4. Receipt of a claim for compensation of costs for treatment of the COVID-19 disease consequences, which developed in the Insured Person outside the terms and the Place of Validity of this Agreement;

4.3.5. If the treatment of the laboratory confirmed COVID-19 disease in the Insured Person was carried out in **private** medical institutions.

4.3. The Insurer does not reimburse the following costs:

4.3.1. Associated with the diagnosis, treatment, observation of the specific Insured Person in case of recurrent COVID-19 disease during the term of this Agreement;

4.3.2. Related to the diagnosis and / or treatment of any disease or condition other than COVID-19;

4.3.3. Expenses for the Observance, the need for which is not related to the COVID-19 disease in the Insured Person;

4.3.4. Expenses for the stay of the Insured Person at the Observation (except food), which, according to the legislation of Ukraine, must be provided to the Insured Person free of charge.

4.3.5. if the treatment of laboratory-confirmed COVID-19 disease was performed in private commercial medical institutions, not agreed with the Assisting Company or the Insurance Company.

4.3.6. Repeated illness during the term of the contract.

4.4. The insurer does not reimburse the following expenses:

4.4.1. Related to diagnosis, treatment, Observation of a specific ZO in case of re-illness with COVID-19 during the term of this Agreement;

4.4.2. Associated with the diagnosis and / or treatment of any disease or condition other than COVID-19;

4.4.3. the cost of the Observation, the need for which is not related to the disease of COVID-2019;

4.4.4. expenses for the stay of ZO on the Observation (except food), which, according to the legislation of Ukraine, must be provided to the Insured person free of charge.

4.4.5. The cost of translator services related to diagnostics and / or treatment and / or Observation in case of COVID-19 disease in the Insured Person, moral harm, other additional costs not provided for in this Agreement.

4.4.6. Experimental treatment cost; medical procedures, manipulations, incl. for the purpose of prevention (vaccination, immunization, vitaminization, etc.), treatment in dispensaries and sanatoriums; rehabilitation; homeopathic and phytotherapeutic treatment;

4.4.7. The cost of general action stimulants, biologically active additives (BAA) and food additives, general action enzymes, prostaglandins, chondroprotectors, hepatoprotectors, saline solutions, enzymes, probiotics, immunomodulators, bacteriophages, disinfectants, hygiene and care items, shampoos, creams, pastes, diapers, etc.;

4.4.8. The cost of consulting a homeopath, immunologist, etc.;

4.4.9. The cost of drugs - tumor necrosis factor inhibitors, monoclonal antibodies, lipid-lowering drugs.

4.4.10. The cost of drugs whose names are absent in the COVID-19 Treatment Protocols approved by the Ministry of Health of Ukraine.

4.4.11. Medical expenses for one Insured Event, in case the duration of the Insured Person's treatment is more than 30 (thirty) days from the date of laboratory confirmation of the COVID-19 disease;

4.4.12. Medical expenses for inpatient treatment of COVID-19 patients with a mild and medium course of this disease;

4.4.13. Medical expenses for the diagnosis and treatment of COVID-19 on an outpatient basis.

4.4.14. illness due to an insured event, in connection with which the Insured Person was in outpatient / inpatient treatment before concluding this Agreement and / or the diagnosis of the disease was known to the Insured Person before concluding this Agreement, taking into account the terms of clause 4 of the Agreement;

4.4.15. recurrence of the disease provided by the insured events during the term of this Agreement;

4.4.16. poisoning by alcohol and its surrogates, narcotic or toxic drugs, as well as drugs not taken on prescription, taken for the purpose or in a state of intoxication;

4.4.17 caused by bodily or other damage to health during self-medication or during treatment by a person without appropriate medical education.

4.5. Events are not recognized as insured events and no damage is reimbursed:

4.5.1. non-material nature (moral damage) and other indirect damages;

4.5.2. which occurred outside the scope of the Agreement and which did not occur during the term of the Agreement.

4.6. The insurer is not responsible:

4.6.1 for adverse consequences of diagnostic, therapeutic and preventive measures (including drug injections), which are related to the treatment carried out in connection with the insured event that occurred during the term of the Contract.

4.6.2. For services in excess of those required for emergency care.

4.6.3. Any costs in the event that the Insured is entitled to free medical care.

4.6.4. Expenses of companions or family members of the Insured Person during hospitalization of the Insured Person.

4.6.5. Expenses not provided for in the Insurance Contract and the selected Insurance Program.

4.6.6. Expenses related to force majeure, which are provided by the Insurance Contract

5. RIGHTS AND OBLIGATIONS OF THE PARTIES AND OF THE INSURED PERSON

5.1. The Policyholder has the right:

5.1.1. To verify the fulfillment by the Insurer of the terms of the Agreement and require the Insurer to pay the Insurance Claims in favor of the Insured Person in the amount and in the manner provided for by the Agreement upon occurrence of the Insured Events.

5.1.2. To appeal the refusal of the Insurer to pay the Insurance Claim or its amount in the manner prescribed by the current legislation of Ukraine.

5.1.3. To change the terms of the Agreement and terminate the Agreement ahead of schedule on the conditions provided for by this Agreement.

5.1.4. To receive from the Insurer any information regarding the terms of the concluded Agreement.

5.1.5. Contact the Assisting Company at the event of the Event for instructions on how to obtain the necessary assistance from the Insured Person.

5.2. The Policyholder undertakes:

5.2.1. To pay Insurance Premium in a timely manner in the amount and within the terms specified in the Agreement.

5.2.2. When concluding the Agreement, to provide the Insurer with information about all circumstances known to the Policyholder that are essential for assessing the Insured risk, and further to inform the Insurer about any change in the Insured risk within 2 (two) working days from the date of receipt of information about the changes.

5.2.3. To inform the Insurer about other valid insurance agreements in relation to this insurance subject.

5.2.4. To acquaint the Insured Person, who is not the Policyholder, with the terms of the Agreement, if the latter is concluded in relation to such a person.

5.2.5. To inform the Insurer about the occurrence of the Event with the Insured Person in the manner and within the time frame provided for in the Agreement according to item 6.1.

5.2.6. Within the limits of its competence, to take measures to eliminate harmful factors affecting the health of the Insured Person and take all possible measures aimed at reducing losses caused as a result of the occurrence of the Event with the Insured Person.

5.3. The Insured Person has the right:

5.3.1. In case of the Insured Event, with due contact with the Assistance (the Insurer), to receive the services provided for in the Agreement in the amount specified in the Agreement.

5.3.2. Upon the occurrence of the Event, to coordinate with the Assistance or the Insurer all the actions related to treatment, receiving medical or other services and paying for the cost of services received under the Agreement, to follow the relevant instructions / recommendations of the Assistance and the Insurer related to the Event.

5.4. The Insured Person undertakes:

5.4.1. To inform the Insurer about the occurrence of the Event in the manner and within the time frames provided for by the Agreement, to act in accordance with the provisions of the Agreement, following all the recommendations of the Assistance and the Insurer.

5.4.2. To provide, at the request of the Insurer, any information required in order to establish the fact of the occurrence (circumstances) of the Event, to determine the amount of Insurance Claim.

5.4.3. In regard to the circumstances of the Event, to release the Third Parties from the obligation not to disclose medical and commercial secrets in relation to the Insured Person, as well as, at the request of the Insurer, to provide the latter with the necessary powers to receive from the Third Parties (doctors, medical institutions, other organizations that provided services to the Insured Person, stipulated by the terms of the Agreement) any information related to the Event.

5.4.4. If you need to receive medical services under the Agreement, reliably inform the Assistance, the medical institution and the Insurer about the state of your health and the existing risks of its deterioration.

5.4.5. In case of providing inaccurate information to Assistance or the Insurance Company, the Insurer has the right to refuse to provide services. The insured person is obliged to return the compensation in full

5.4.6. Properly store insurance documents and not pass them on to others for medical care; in case of loss of insurance documents, immediately notify the Insurer

5.4.7. The insured person must strictly follow and follow the doctor's recommendations.

5.5. The Insurer has the right:

5.5.1. To verify the information provided by the Policyholder when concluding the Agreement, as well as the fulfillment by the Policyholder (Insured Person) of the requirements and conditions of the Agreement.

5.5.2. To find out independently the reasons and circumstances of the occurrence of the Event.

5.5.3. If necessary, to request additional information related to the occurrence of the Event from the competent authorities: medical institutions, law enforcement agencies, other enterprises, institutions and organizations that have information about the circumstances of the Insured Event, and also have the right to independently

5.5.4. To refuse in whole or in part the Insurance payment in the cases specified in the Agreement according to section 4.

5.5.5. To require the Policyholder (the Insured Person) to provide information and documents necessary to establish the circumstances of the occurrence of the Event, including information constituting a commercial and medical secret, and verify the accuracy of this information.

5.6. The Insurer undertakes:

5.6.1. To acquaint the Policyholder with the terms and conditions.

5.6.2. Within 2 (two) working days, as soon as it becomes known about the occurrence of the Insured Event, to take measures to complete all the necessary documents for the timely payment of the Insurance Claim.

5.6.3. In case of the Insured Event, to pay the Insurance Claim in accordance with the terms of the Agreement, by reimbursing the documented costs of receiving medical and sanitary and other assistance by the Insured Person during the Insured Person's travel (trip). The Insurer bears property liability for untimely payment Insurance Claims by paying the Insured Person a penalty, the amount of which is 0.01% of the amount owed for each day of delay, but not more than double NBU discount rate.

5.6.4. To monitor the timeliness and necessity of providing the Insured Person with the services stipulated by the Agreement.

5.6.5. In case of refusal to pay the Insurance Claim, to notify the Insured Person and the Policyholder about this in writing, with a reasoned justification of the reasons for the refusal, in the manner and time specified in the Agreement.

6. ACTIONS OF THE POLICYHOLDER (INSURED PERSON) AND ASSISTANCE IN CASE OF THE EVENT

6.1. Upon the occurrence of the Event that has signs of the Insured Event (the need to receive the services provided for in the Agreement), the Insured Person (Policyholder) within the shortest possible period, but, in any case, no later than 24 hours, must:

6.1.1. Contact the Assistance by phone numbers specified in the Agreement and receive information on further actions.

6.1.2. Provide the Assistance with the following information:

1) surname, name of the Insured Person;

2) number of the Insurance Agreement and its validity period;

3) location of the Insured Person;

4) contact phone number;

5) reason for the appeal (complaints, health problems);

6) number and date of a positive PCR test for SARS-CoV-2 coronavirus (if any).

6.2. The Assistance, after receiving the information specified in clause 6.1.2 of this Section:

6.2.1. Performs identification of the Insured Person and checks the validity of the Insurance Agreement;

6.2.2. Establishes whether the Insured Person has the results of a PCR test with a positive conclusion (SARS-CoV-2 coronavirus RNA detected);

6.2.3. provides advice;

6.2.4. if necessary, in the presence of signs of a severe course of the COVID-19 disease, organizes the provision of urgent and / or emergency inpatient care.

NOTE. The selection of an inpatient medical institution to provide the Insured Person with emergency inpatient care is within the competence of the Assistance (the Insurer).

6.3. When the Assistance performs the actions specified in clause 6.2 of this section, the Insured Person must:

6.3.1. Follow all instructions provided by the Assistance (the Insurer)

6.3.2. Submit to the SIMI a document (with a photo) certifying the identity of the Insured Person and the Insurance Agreement;

6.3.3. Warn the employees of the medical institution (doctor) about the possibility of the Insurer applying with requests for additional information necessary to ascertain the health status of the Insured Person, and provide written permission for the medical institution to provide such information to the Insurer.

6.4. If the Insured Person needs urgent medical assistance, and it is impossible to inform about it before receiving it **for objective reasons**, then the Insured Person can independently contact the urgent medical assistance or the SIMI by phone. In this case, the Assistance or the Insurer should be informed thereof as soon as it becomes possible, but no later than 24 hours after receiving such assistance. These actions on behalf of the Insured Person can be performed by any Third Party who is nearby and can act on behalf of the Insured Person: relative, coworker, employee of a medical institution, doctor, etc.

NOTE. Objective reasons, in this case, can, in particular, be considered:

- state of unconsciousness of the Insured Person (in the absence of a person representing his/her interests);

- lack of effective means of communication at the location of the Policyholder (the Insured Person).

The existence of objective reasons must be proven by the Insured Person with documents.

7. LIST OF THE DOCUMENTS CONFIRMING THE OCCURENCE OF THE INSURED EVENT

7.1. The Insurer pays (within the Insured Sum and the limits established by the Agreement) the cost of services provided to the Insured Person in accordance with the terms of the Agreement, based on the invoices of medical institutions, or provided to the Insurer through Assistance, or reimburses the Insured Person for the amounts paid for these services provided to the Insured Person.

7.2. The documents required for settlements between the Insurer and the Assistance are determined in accordance with the relevant agreements concluded between the Assistance and the Insurer.

7.3. In case of self-payment by the Policyholder (the Insured Person) for the services provided to the Insured Person in accordance with the Agreement, the Insurer pays the Insurance Claim based on the following documents:

7.3.1. application of the Insured Person (the Policyholder) for payment of the Insurance Claim in the form established by the Insurer;

7.3.2. original / certified copies of this Agreement;

7.3.3. if the Insured Person is provided with emergency and urgent inpatient care related to the COVID-19 disease: - the original of the medical documentation - the epicrisis / extract from the medical history with detailed information about the disease of the Insured Person and the peculiarities of its course, drawn up properly in a medical institution, full name of the Insured Person, date of birth, date of seeking medical assistance, date of a positive conclusion on COVID-19 disease in the Insured Person, period of stay of the Insured Person in a medical institution; medical history; clinical picture, examination results that confirm the COVID-19 disease in the

Insured Person, test results, in particular, based on PCR; the results of the use of radiation diagnostic methods (X-ray, computed tomography - CT), blood tests, urine tests, other examinations confirming the severity of the disease; recommendations of doctors, information on a direct causal relationship between the COVID-19 disease and the hospitalization of the Insured Person in the SIMI. These documents must be certified by the signatures of the attending physician, the head physician of the medical institution on the blank and the seal of the medical institution;

7.3.4. These documents must be certified by the signatures of the attending physician, the head physician of the medical institution and the seal of the medical institution.

7.3.5. Original detailed invoices for other services provided for by the Agreement, broken down by dates and costs, the total amount to be paid;

7.3.6. Original documents confirming the incurrence of costs provided for in the Agreement and the fact of payment for medicines, medical and other services provided (settlement and cash documents, sales receipts, with the specified amount for transfer, etc.);

7.3.7. copies of the foreign passport (or children's travel document) of the Insured Person with border control marks on crossing the state border of the Country of permanent residence;

7.3.8. copies of the passport of the Insured Person's;

7.4. Taking into account the specific circumstances of the Event, the Insurer has the right to require reasonably additional documents to confirm the fact and circumstances of the occurrence of the Insured Event.

7.5. All documents must be legibly written or printed on letterhead and have the appropriate seals and signatures, as well as the name, address and contact phone number of the institution (organization) that issued the document.

7.6. The documents specified in this section may be provided to the Insurer in the form of: original copies; notarized copies; simple copies, certified by the authority that issued the relevant document, or in the form of simple copies, provided that the Insurer is given the opportunity to reconcile them with the original copies of the documents.

7.7. If the documents specified in this section are provided to the Insurer in improper form or executed in violation of general rules (no number, date, stamp, seal, text correction, etc.), the Insurance Claim is not paid until these deficiencies are eliminated.

7.8. An application for payment of the Insurance Claim and other documents required for making payment shall be submitted to the Insurer no later than fifteen (15) calendar days after the end of the treatment period.

8. PROCEDURE AND TERMS OF PAYMENT INSURANCE CLAIMS

8.1. Within 15 (fifteen) working days after receiving from the Policyholder (the Insured Person, the Third party) all duly executed documents specified in clause 7.3, Section 7, Part B of the Agreement), the Insurer decides on payment of the Insurance Claim and draws up the corresponding Insurance Act, or makes a decision to refuse to pay the Insurance Claim and within 10 (ten) working days from the date of such a decision (unless another period is provided for by the Agreement), notifies the person who drew up an application for payment the Insurance Claim (the Policyholder, the Insured Person), with justification of the reasons for the refusal.

8.2. If a decision to pay the Insurance Claim is made, the latter is paid within 15 (fifteen) working days from the date of the Insurer's decision.

8.3. The Insurer pays the Insurance Claim as follows:

8.3.1. To the Assistance, who paid the expenses for the services of the Specialized Institution provided to the Insured Person.

8.3.2. To the Insured Person (the Policyholder) who independently paid for the services rendered, subject to the conditions and restrictions specified in the Agreement.

8.4. Transfer of funds to the Assistance's account is carried out on the basis of documents confirming the occurrence of the Insured Event and determining the cost of the necessary services actually provided to the Insured Person. The form of these documents and the terms of settlements are agreed between the Insurer and the Assistance.

8.5. The amount of the Insurance Claim that is paid to the Insured Person (the Policyholder), subject to the provision of all documents specified in section 7 of part B of the Agreement, confirming the fact of the occurrence of the Insured Event, the fact and amount of payment for the received assistance (services), is determined as follows:

8.5.1. subject to the preliminary agreement of the list of services and the amount of expenses with the Assistance or the Insurer/ Insured Person (before their payment), the Insurer pays the cost of the services provided (expenses incurred) in full within the Insured Sum (liability limit) under the Agreement;

8.5.2. if the expenses of the Insured Person (list of services provided) have not been agreed with the Assistance or the Insurer, the latter reimburses only the amount of expenses within 500 UAH.

8.6. In the event that the Insured Person, for objective reasons, did not turn to the Assistance to receive the necessary assistance (services), and, as a result, must independently pay the cost of the assistance (services) provided, the Insured Person must agree with the Assistance or the Insurer the invoice issued by the Specialized Institution (the validity of the amount of expenses for the services provided) before payment.

8.7. If the Policyholder (the Insured Person) has not taken the necessary and reasonable measures to prevent and reduce the costs arising from the Event, as well as to eliminate the causes that contribute to the emergence of additional costs, the Insurer has the right to reduce the Insurance Claim by the amount of additional damage. In particular, the Insurer has the right to reduce the Insurance Claim in the event that the Insured Person fails to comply with the doctor's recommendations, which has led to a deterioration in the Insured Person's health and, as a result, an increase in medical expenses for the treatment of the Insured Person.

8.8. The grounds for the refusal of the Insurer to pay the Insurance Claim are:

8.8.1. Intentional actions of the Policyholder (the Insured Person) aimed at the occurrence of the Insured Event. This norm does not apply to actions related to the performance of civil or service duty, in a state of necessary defense (without exceeding its boundaries) or protection of property, life, health, honor, dignity and business reputation. The qualification of actions of the Policyholder (the Insured Person) is established in accordance with the current legislation of Ukraine.

8.8.2. Committing by the Policyholder (the Insured Person) of an intentional crime that led to the occurrence of the Event.

8.8.3. Submission by the Policyholder (the Insured Person) of knowingly false information about the Insured Person or about the fact and / or circumstances of the occurrence of the Event.

8.8.4. Untimely notification by the Policyholder (the Insured Person) about the occurrence of the Event without good reason or the creation of obstacles to the Insurer in determining the circumstances, nature and consequences of the Event.

8.8.5. The presence of the circumstances provided for in Section 4 of this Part of the Agreement.

8.8.6. Failure by the Policyholder (the Insured Person) to fulfill their obligations specified in clauses 5.2, 5.4, Section 6 of this Part of the Agreement.

8.8.7. Absence (partial or complete) of the documents specified in Section 7 of this Part of the Agreement and necessary for payment of the Insurance Claim.

8.8.8. Other cases provided by law.

9. TERMS OF TERMINATION AND AMENDMENT OF THE INSURANCE AGREEMENT

9.1. The Agreement is terminated and becomes invalid by agreement of the Parties, as well as in the following cases:

9.1.1. expiration of its validity period;

9.1.2. the Insurer fulfills its obligations under the Agreement in full;

9.1.3. failure of the Policyholder to pay the Insurance Premium within the time period specified in the Agreement;

9.1.4. liquidation of the Policyholder - a legal entity or death or loss of legal capacity by the Policyholder - an individual, except for the cases provided for by Articles 22, 23, 24 of the Law of Ukraine "On Insurance";

9.1.5. liquidation of the Insurer in the manner prescribed by the legislation of Ukraine;

9.1.6. court decision on the invalidation of the Agreement;

9.1.7. in other cases provided for by the legislation of Ukraine.

9.2. The Agreement may not be terminated by the Insurer ahead of time without the consent of the Insured, who fulfills all the terms of the Agreement.

9.3. Any Party must notify the other Party of its intention to terminate the Agreement ahead of schedule no later than 30 (thirty) calendar days before the expected date of termination of the Agreement.

9.4. In the event of early termination of the Agreement at the request of the Policyholder, the Insurer returns to the Policyholder the Insurance Premium for the period remaining until the expiration of the Agreement, minus the standard case management costs (40%), determined by the Rules, the amounts of actual Insurance Claims made under this Agreement.

9.4.1. If the request of the Policyholder is due to the violation by the Insurer of the terms of the Agreement, the latter returns to the Policyholder the Insurance Premiums paid by the Policyholder in full.

9.5. In case of early termination of the Agreement at the request of the Insurer, the Insured shall be refunded the Insurance payments paid in full by him.

9.5.1. If the request of the Insurer is due to the Policyholder's failure to comply with the terms of the Agreement, the Insurer returns to the Policyholder the Insurance Premium for the period remaining until the expira-

tion of the Agreement, minus the standard case management costs (40%), determined by the Rules, the amounts of actual Insurance Claims made under the Agreement.

9.6. Any changes and additions to the Agreement can be made only with the consent of the Parties, by drawing up an appropriate Supplementary Agreement to this Agreement.

9.7. In case a person uses an insurance policy, the funds for which were returned to him by the insurance company, the State Border Guard Service of Ukraine will be informed about this fact. The above may in the future be a precondition for the refusal of such a person to cross the state border of Ukraine, or his deportation from Ukraine.

10. DISPUTES RESOLUTION PROCEDURE

10.1. Disputes between the Parties to the Agreement should be resolved through negotiations.

10.2. If it is impossible to resolve disputes through negotiations, they should be resolved in court, in accordance with the current legislation of Ukraine.

11. FINAL PROVISIONS

11.1. If any provision of the Agreement becomes invalid, this does not lead to the invalidity of the entire Agreement as a whole.

11.2. Insurance relationships not specified in the Agreement are regulated in accordance with the Rules and legislation of Ukraine.

11.3. Prior to signing the Agreement, the Policyholder familiarized themselves with the Rules and agreed to the terms of this Agreement.

11.4. The terms of the Agreement are trade secrets and are not subject to disclosure by the Parties, except for cases directly provided for by the legislation of Ukraine.

11.5. Within the framework of this Agreement, all messages are considered duly submitted if they are sent by registered mail, by means of electronic or facsimile communication (with confirmation of receipt) or delivered by courier to the addresses specified in the Agreement.

11.6. In pursuance of the requirements of the Law of Ukraine "On the Protection of Personal Data", by concluding this Agreement, the Policyholder provides the Insurer with consent and confirms that the appropriate consent is received from the Insured Persons (except for the Insured Person, whose legal representative is the Policyholder) regarding:

11.7. By signing this Agreement, the Policyholder, on its own behalf and on behalf of the Insured Person, confirms receiving from the Insurer a proper notification of the personal data entering to the Insurer's database(s), explanation of the respective rights of the Policyholder and the Insured Person, as well as information about the purpose of collecting such data.

11.8. By signing this Agreement, the Policyholder, on its own behalf and on behalf of the Insured Person, confirms receiving information specified in Part 2 of Article 12 of the Law of Ukraine "On Financial Services and State Regulation of Financial Services Markets", clarifying the right to information, understanding of the ess.

11.9. By signing the Agreement, the Policyholder confirms that all the Insured Persons specified in Section 3 "Data on the Insured Persons" of Part A of the Agreement, in respect of which the Policyholder is not a legal representative, have given their consent to insurance, in accordance with the terms of the Agreement, and have also granted the right to the Insurer to receive the necessary information from medical institutions about the health status of the respective Insured Persons and the medical services received by them and release medical workers from the obligation to observe medical secrecy in relation to information related to the Insured Event stipulated by this Agreement.

Deputy of the
Chairman of the Board
PJSC “IC “INTER-PLUS”
Bonkovska I.V.

Bonkovska I.V.