Additional Critical Illness Insurance Rules No. P03

[Effective since 14 March 2011]

Definitions used in the Additional Critical Illness Insurance Rules No. P03

1. Main insurance means the insurance under the standard terms established in the Life Insurance Rules ('life insurance' definition covers such types of insurance as the risk insurance, endowment and unit-linked life insurance.
2. The additional insurance means the supplementary insurance to the main insurance agreement between the policyholder and the insurer under the standard insurance terms, established in the Additional Critical Illness Insurance Rules No. P03. The policyholder shall familiarise with the additional insurance rules prior to signature of the application to use the additional insurance terms (the additional coverage) and the present rules shall be deemed to be an integral part of the insurance agreement. The additional insurance shall be valid only jointly with the main insurance.
3. Critical illness means any illness or sickness (condition) specified in the list of critical illness, identical to the specified description and meeting the diagnostic criteria.
4. A list of critical illness means the list of illness or sickness (condition) identical to the specified description and meeting the diagnostic criteria, the occurrence of which within the insurance validity period is deemed to be the insured event.
5. Other definitions used in the present rules, which are not specially defined in this part, shall have the same meaning as in the main insurance rules.

Validity of the additional insurance

6. Terms of the additional insurance shall come into effect after issuance of the insurance policy or an annex hereto, proving the additional insurance coverage for the insured person.
7. The additional insurance shall be valid only jointly with the main insurance.

Terms of the additional insurance established in the main insurance rules

8. The additional insurance rules shall establish the procedure to be followed when taking the actions related to the additional insurance if necessary to:
   - 8.1 make amendments to the insurance agreement, if amendments are made to the additional insurance terms;
   - 8.2. suspend the additional insurance cover in cases specified in the main insurance rules;
   - 8.3. assign the insurer's /policyholder's rights and obligations under the insurance agreement to another insurer / policyholder;
   - 8.4. send notifications or any other information;
   - 8.5. resolve any dispute.
9. Rights and obligations of the parties to the insurance agreement are established in the main insurance rules.
10. The provisions of the main insurance rules shall be valid for the additional insurance, except for the provisions that provide otherwise in the additional insurance rules.

Object of insurance

11. The object of insurance under the additional critical illness insurance – is the property interest related to the insured person's health.
12. If the additional insurance under the insurance agreement comes into effect, the object of insurance specified in the insurance agreement shall be supplemented with the object of insurance established in the present rules.
13. The insured person on the effective date of the critical insurance may not be older than 55 years of age, and at the end of the insurance period may not be older than 70 years of age.

Sum insured

14. Sum insured under the additional insurance shall be identified by mutual consent between the policyholder and the insurer and shall be specified in the insurance policy or an annex hereto.

Insurance premium

15. The insurance premiums under the additional insurance shall be paid together with the insurance premiums under the main insurance.
16. The insurance premium to cover the additional insurance risk shall be paid following the procedure established in the main insurance rules. The risk premium under the additional insurance shall be included in the main insurance premium or deducted from the main investment provisions, taking into consideration the procedure established in the main insurance rules.
17. The policyholder shall be familiarised with the insurance premium and / or the pricelist that indicates the additional insurance fees prior to signature of the application to use the additional insurance.
18. The insurer shall have a right to unilaterally change the insurance fees in cases and following the procedure established in the main insurance rules. If the policyholder disagrees with the changes in the insurance fees, the policyholder shall have a right to make free of charge changes in the insurance agreement, and to refuse of the additional insurance.

Insured events

19. An insured event, except for the cases listed in Item 21, is the insured person's critical illness is diagnosed within the insurance cover validity period and if it meets the definitions specified in the list of critical illness and to the established diagnostic criteria.
20. Taking into consideration the developments in medical science and significant changes in the risks accepted by the insurer, the insurer shall have a right to unilaterally make amendments to the definitions of the critical illness and diagnostic criteria. If the policyholder disagrees with such amendments, the policyholder shall have a right to make changes in the insurance agreement free of charge, and to refuse of the additional insurance.

Non-insured events

21. A non-inured event means the insured person's critical illness, or sickness (condition) related to:
    - 21.1. illness if the insured person falls ill within the first six months from the effective date of his/her insurance agreement, or within the first six months from increase in the sum insured under the critical illness insurance, or that was diagnosed within the insurance cover suspension period, or within the first six months from the insurance cover renewal date;
    - 21.2. illness that does not meet the critical illness definitions specified in the list of critical illness or the established diagnostic criteria;
    - 21.3. insured person's intentional injury or suicide attempts;
    - 21.4. abuse of drugs, strong medicine and toxic substances (except for the use of medication under a prescription issued by licenced healthcare institutions);
    - 21.5. war, military actions (whether war is declared or not), civil war, military take-over, rebellion, military invasion, military actions or occupation, use of military weapons, proclamation of war or state of emergency, mass riots, civil unrest, nuclear power, radioactive contamination;

21.6. criminal activity of the insured person, if the court has ruled that the criminal offence was committed intentionally;
21.7. air transportation accidents, with the exception of passenger flights of the licenced airlines;
21.8. extreme sports and activities, leisure events (motorcycle and other motor vehicle racing, aviation and other aviation sports (flying any type of flying machines, hang- gliding, kite flying, gliding parachutes), diving, mountaineering, other extreme sports and activities (rafting, rock gliding, etc.), if specially not agreed otherwise with the insurer.

22. The insured person's critical illness, sickness (condition), specified in the list of critical illness shall be deemed to be a non-insured event if the healthcare institution regarding the treatment purposes or the insurer – regarding the insurance benefit were contacted with some delay, therefore the insurer is unable to check the event date, circumstances and the medical record documentation does not confirm the fact of existence of the insured event within the validity term of the subject of insurance.

Insurance benefit

23. Upon occurrence of an insured event, the sum insured under the critical illness insurance shall be paid.
24. The insurance benefit in case of any critical illness shall be paid only once irrespective of the number of times the critical illness recurs.
25. If the insured event occurs within the insurance validity period, except in the case established in Item 21, the insurer shall pay the sum insured under the critical illness insurance to the insured person.
26. After payment of the insurance benefit under the critical illness insurance and prior to expiry of 6 months from the date of contacting the insurer, in case of the insured person's death, the insurance benefit to be paid under the main insurance rules shall be decreased by the amount of the insurance benefit paid under the present rules.
27. If the investigation related to the insured person critical illness, sickness (condition), specified in the list of critical illness of the present rules, is performed by the legal enforcement institution or if the litigation is started, the insurer shall have a right to postpone a decision on the insurance benefit until the litigation is finalised.
28. The insurance benefit payment period shall be established in the main insurance rules.

Procedure for the insurance benefit payment

29. The insurer shall be notified of the critical illness, sickness (condition) specified in the list of critical illness of the present rules no later than within 30 (thirty) calendar days from the date of diagnosing such critical illness, sickness (condition). If the insured person undergoes health treatment in the inpatient healthcare institution, it is required to notify the insurer of the insured event no later than within 30 (thirty) from the last day of the insured person's health treatment in the inpatient healthcare institution.
30. In case of requesting the insurer to disburse the insurance benefit, it shall be necessary to submit:
    30.1. filled out notification in the form established by the insurer;
    30.2. application in the form established by the insurer to transfer the insurance benefit to the specified bank account of the beneficiary;
    30.3. documents issued by the healthcare institution including the approved diagnosis, anamnesis, medical tests and prescribed medical treatment, other documents necessary for investigation of the insured event.
    30.4. The insurer may require that a physician selected by the insurer makes a medical examination or that the medical tests are performed by the medical treatment institution selected by the insurer.

The list of critical illness and conditions (situations) occurrence of which within the insurance cover validity period is considered to be an insured event

Myocardial infarction
Coronary bypass surgery
Cerebral infarction (stroke)
Cancer
Renal failure
Organ transplantation
Paralysis
Blindness
Multiple sclerosis
Aortic bypass surgery

Clinical Illness Definition and Diagnostic Criteria

MYOCARDIAL INFARCTION

It is an acute irreversible heart muscle injury (necrosis) which develops for a first time after a sudden interruption of arterial blood flow in a respective myocardial segment.
Diagnosis shall be grounded by all these symptoms and tests results:

- typical chest pain characteristic of myocardial infarction;
- new alterations in an electrocardiogram, characteristic of myocardial infarction;
- significant increase in activity of heart enzymes, troponins or other biochemical myocardial infarction markers (CK-MB, troponin I or T) in blood serum. Significant increase is defined as troponin T (Tn T) level above 1.0 ng/ml or AccU Tn I level above 0.5 ng/ml or equivalent increase above the normal values when the test is performed using other globally accepted methods.

An event shall be considered as a subject of insurance if the diagnosis is grounded by all the above mentioned symptoms and tests results and myocardial infarction is diagnosed by a physician.
All other acute coronary syndromes including angina pectoris are not subjects of insurance.

CORONARY BYPASS SURGERY

It is an open coronary bypass surgery performed to correct stenosis or occlusion of one or more coronary arteries. A superficial blood vessel from the leg, blood vessel from inside of the chest or other suitable artery is used as a graft.
The sum assured is paid only in case clear coronary obstruction has been detected angiographically before the surgery and in doctor cardiologists opinion surgery is required.
Angioplasty and other intraarterial, catheterizing or laser procedures are not considered to be insurance events.

CEREBRAL INFARCTION (STROKE)

It is an acute cerebral circulation disturbance (due to infarction of cerebral tissue, hemorrhage from intracranial blood vessels or due to embolisation from extracranial sources) which is the cause of permanent neurological deficiency condition.
The sum assured is paid only in case neurological deficiency condition becomes permanent. Diagnosis must be supported by new CT scan or BMR tests with evident imaging of changes in the cerebrum. Permanent neurological deficiency condition must be confirmed by a neurology physician at least 6 weeks after cerebral infarction. Cerebral infarction or intracranial bleeding due to external injury (accident) are not considered to be insurance events. No insurance benefit is paid after transitory cerebral ishaemic attacks as well.

CANCER

It is uncontrollable growth, spreading and invasion (penetration) of malignant cells into normal tissue and destruction of healthy tissue. The sum assured is paid only in case when there is undoubted evidence of invasion into tissues, and malignancy of cells is confirmed histologically. Diagnosis must be confirmed by doctor oncologist or pathoanatomist.

Leucaemia, malignant lymphoma, Hodgkin's disease, malignant bone marrow diseases and metastatic skin cancer are all considered to be cancerous diseases. In this case diagnosis must be confirmed by doctor oncologist or hematologist.

No insurance benefit is paid in case such diagnoses have been confirmed:

- local non-invasive cell growth with early signs of malignancy (carcinoma in situ), cervical dysplasia, cervical cancer CIN-1, CIN-2 and CIN-3, and all the precancerous conditions and other non-invasive tumors;
- early prostate cancer, corresponding to T1 (including T1a and T1b) in TNM classification or corresponding cancer stage according to other classifications;
- skin melanoma, stage 1A (based on American Joint Committee on Cancer classification) (≤1mm, level I or II, without ulceration);
- hyperkeratosis, basocellular and planocellular skin carcinomas;
- any type of cancer, in case the insured person is infected with HIV (human immunodeficiency virus) or he is an AIDS patient.

RENAL FAILURE

Terminal stage of renal function insufficiency due to irreversible impairment of renal function. The sum assured is paid in case the insured person has undergone renal transplantation surgery or dialysis procedures are performed regularly.

No insurance benefit is paid in case one kidney is missing after nephrectomy or in case of acute renal failure (if temporary dialysis procedures are required).

ORGAN TRANSPLANTATION

Transplantation surgery of one of the following organs, if an insured person is a recipient:

- heart, lung, liver, kidney, pancreas (if a whole organ rather than a part of an organ is transplanted);
- human bone marrow transplantation using haemopoetic stem cells, if bone marrow has been completely removed before the surgery.

Transplantation surgery must be of vital importance and substantiated by fact that there is a terminal stage organ insufficiency.

The sum assured is paid only in case the insured person is included into an official list of patients waiting for surgery (surgery is necessary due to vital indications and no contraindications are present).

Surgery of all the stem cells, not mentioned above is not considered to be an insurance event.

Insurance benefit is not supposed to be paid for donors.

PARALYSIS

Complete incurable permanent loss of function of two or more extremities due to trauma or illness of cerebrum or spinal cord, permanent nature is confirmed by neurology physician. The loss of extremities function, classified as diplegia, hemiplegia, teraplegia and quadriplegia is considered to be an insurance event.

Insurer has a privilege to delay the decision about the payment of insurance benefit for 6 months. Insurance benefit will be paid in case the function of the extremity does not appear after 6 months.

BLINDNESS (loss of vision)

Complete permanent both eyes loss of vision due to trauma or disease. Diagnosis must be confirmed by doctor ophthalmologist by means of clinical and instrumental tests. There must be no possibility to correct blindness by means of any medical remedies or techniques.

MULTIPLE SCLEROSIS

Multiple neurological deficiency condition lasting more than six months due to demielinisation of cerebrum and spinal cord. Diagnosis must be certain, confirmed by neurology physician clearly and definitely more than once in parallel with manifestation of several neurological symptoms listed: optical nerve, bulbar, spinal cord, coordination, sensory function symptoms.

AORTIC BYPASS SURGERY

Thoracical or abdominal aorta section open surgery due to life threatening artery disease; the damaged segment of aorta is removed and replaced with a graft. Insurance benefit will be paid only in case of surgery performed on the thoracic or abdominal section of aorta. Insurance benefit will not be paid if minimal invasive stunting procedure, aorta branch surgery is performed or in case surgery is required due to trauma.