

Euromed Diamond

SPECIAL TERMS AND CONDITIONS

1. **INSURANCE COMPANY:** New India Assurance Co. Ltd.
2. **POLICY HOLDER:** Nationals and Expatriates, who for professional reasons or for purposes of professional training are spending a period of residence in the U.A.E. or other AGCC countries. Only 1 policy holder can be nominated per family.
3. **INDIVIDUALS INSURABLE:** Individuals, Families & Groups upto the age of 60 years. However, persons residing as singles or divorcees can also be insured. Only life partners and children living under a single domestic roof are counted as family members. Persons whose occupation includes mostly physical work (blue – collar – jobs) cannot be insured.
4. **AREA OF APPLICATION:** UAE/ South East Asia/ Indian Subcontinent/ GCC Countries.
5. **EARLY TERMINATION:** The insurance may be terminated by the person insured at any time in writing, cancellation charges of AED 250/- is payable by each insured, refund of the premium will be applicable upon termination if no claims exists. However, there will be no refund applicable for dependents that are included mid year and wish to terminate the cover.
6. **BENEFITS:**
 - **OUTPATIENT TREATMENT:** 100% of the bill payable for treatment in the Network facility & 70% of the bill payable for treatment in Non-network facility.
 - **HOSPITAL TREATMENT:** 100% of the reclaimable costs of medically necessitated in – patient treatment in approved network hospitals, including operations, X- rays and radiation treatment and diagnosis & 70% of the bill payable for treatment in Non-network facility.
 - **PHARMACEUTICALS, BANDAGES AND MEDICINES:** 100%, if prescribed by an approved network doctor.
 - **DENTAL TREATMENT:** Only if necessitated by an accidental injury.
 - **PREVENTIVE CHECKUPS:** None
 - **BENEFITS IN CONNECTION WITH PREGNANCY AND CHILDBIRTH:** None
 - **TOOTH REPLACEMENT:** None
 - **HEARING OR VISUAL AIDS:** None
 - **COVER:** We will provide cover for the treatment of medical condition, which first manifest themselves during period o cover and where treatment is actually given during the current period of cover.
7. **TREATMENT TAKEN OUTSIDE THE NETWORK:** For treatment taken in any hospital, clinic or medical establishments outside the network, the insured person will be self-insurer upto the extent of 30% while the company will reimburse only 70% of the claim provided the treatment is within the scope of the policy. For all tests and treatments which require pre authorization, if not taken, the insurance company will not be liable to pay the claim. A verbal confirmation does not constitute pre approval.

8. ELECTIVE TREATMENT: For elective treatment in any country other than the current country of residence, it is necessary to notify and to take prior approval from the insurance company where such request will be speedily dealt with and not unnecessarily withheld. The approval rules out the chances of disproportionate charges being levied or unnecessary treatment being carried out by the provider. However, if such approval is not taken, the claim will be reimbursed upto a maximum of 70% of the cost that would have become payable if similar treatment was taken in any premium hospital in the U.A.E. or any other AGCC country where the insured is currently resident or the cost of the incurred claim – which ever is lower, provided the treatment is within the scope of the policy.

9. RENEWALS: If the policy is not renewed before/on the expiry, (break in cover), we reserve the right to treat the application as a fresh case, all previous claims would then stand as exclusion to the new policy. Upon renewal of the policy if a member wishes to upgrade from Euromed Silver to Euromed Gold or Euromed Diamond or Euromed Platinum, the same can be done. However, it's mandatory that all the members in the policy are upgraded.

10. PREMIUM PAYMENTS: The premium is an annual premium. It becomes due for payment at the time of inception or at every annual renewal. In the event of non-payment of premium with seven working days of receiving the policy; we shall be entitled to cancel the policy with immediate effect. **Employee inclusions** to a group policy will be charged pro rata premium, dependents of employees/individuals will be charged full premium (pro rata adjustments will be done at the time of renewal) however, no refund will be applicable to the dependents of the insured if cover is terminated mid year or policy is not renewed.

11. RE IMBURSEMENT CLAIMS: Claims submitted after 90 days of treatment will not be payable by the insurance company. All claims should be submitted in original supported with our claim form duly filled.

12. OTHER MATTERS: Subsequent switching between the Euromed Silver to Euromed Gold or Euromed Diamond or Euromed Platinum tariffs is not permitted mid year. No pension reserve fund will be established. The insurance company is not obligated to provide a follow-on coverage after termination of this insurance cover. You are recommended to take out a deferred insurance policy, e.g, with a statutory health insurance scheme. Upon renewal of the policy if a member wishes to upgrade Euromed Silver to Euromed Gold or Euromed Diamond, or Euromed Platinum, the same can be done, however, previous claims will stand as exclusion to the new policy.

GENERAL EXCLUSIONS

EUROMED DIAMOND

- 1 Pre existing disease of any kind.
- 2 Pregnancy, Child birth and related.
- 3 Illness consequent to active participation in war, civil disturbances etc.
- 4 Illness consequent to participation in professional sports.
- 5 Accidental injury or illness caused by attempted suicide or intentional self injury
- 6 Any kind of treatment for mental or emotional disturbances, hypnosis or psychotherapy.
- 7 Vaccinations inoculations and the like.
- 8 Illness consequent to neglecting administration of protective inoculations or vaccines required as per statute.
- 9 Treatment at health hydros, spas, nature care clinic and the like
- 10 Alcohol, drug or substance abuse and all related complications.
- 11 Infertility or related and birth control or related
- 12 Cosmetic plastic surgery not necessitated by any accident or disease.
- 13 Birth defects or congenital diseases.
- 14 Circumcision.
- 15 Routine medical examination.
- 16 Orthodontic, bridges, crowns, gingivitis, periodontitis, root canaling any form of surgical dental treatment
- 17 Hearing and Visual aids.
- 18 Pharmaceuticals, bandages and medicines if not prescribed by the treating doctor.
- 19 Sexually Transmitted Diseases, HIV and related.
- 20 Rehabilitation.
- 21 Nursing at home
- 22 Sleep Apnea and Snoring
- 23 Vocational Speech Therapy

- 24 Eating disorders.
- 25 Sex Change Operations.
- 26 Varicose veins – (covered only if medically required)
- 27 Complimentary therapies like Homeopathy and the like.
- 28 Well Baby Clinic
- 29 Obesity and any treatment and related conditions .
- 30 Deviated Nasal Septum – If medically required
- 31 Skin disorders – Covered upon case to case basis
- 32 Organ or tissue transplant – Recipient insured member only
- 33 Hair and scalp treatment
- 34 Work related problems
- 35 Auto therapy
- 36 Dental Treatment except when necessitated due to accidental injury

EXCLUDED PHARMACY ITEMS

The items listed below are **not covered** by any of the Schemes.

1. Antiseptic solutions (Douche/Savlon)
2. Baby formula.
3. Braces
4. Breast Pump
5. Contraceptive medicines
6. Cosmetic preparations (creams/lotions)
7. Contact lens preparations
8. Crutches
9. Dietary Supplements
10. Exercise machines
11. Glucometer
12. Heel pads and Arch Supports
13. Hormone replacement Therapy
14. Hearing Aids
15. Infertility medications
16. Impotence medications
17. Lumber Supports and corsets
18. Mood altering medications
19. Mouth gargles and mouth washes
20. Massage machine
21. Mouth guards
22. Nebulizer machine
23. Other joint supports
24. Orthopedic consumables (bandages etc)

25. Orthotics
26. Psychiatric medication
27. Soaps and Shampoos
28. Support stockings and pantyhose
29. Slings
30. Tooth brush/floss/paste
31. Vitamins
32. Vaccinations

PRE AUTHORIZATION

1. All Direct Hospital Admissions
2. AIDS Test
3. Ambulatory Surgery
4. Ba Enema
5. Bone Density
6. Cardiac Diagnostic Studies/ Holter Monitoring
7. CMV
8. CT Scan
9. Doppler Studies
10. Echocardiogram
11. All Endoscopic Procedures
12. EEG
13. EMG
14. Hormonal Tests
15. Herpes Test
16. Lithotripsy
17. Hystersalphinography
18. IVP
19. MRI

20. MCU
21. Mammogram
22. Nuclear Studies
23. Procedures(Including Intra Articular Injection)
24. Physiotherapy
25. Pap Smear
26. Rubella Test
27. EKG
28. Stress Echo
29. Specialist Consultation
30. Thyroid Function Tests (T3, T4,TSH)
31. Toxoplasma Test
32. Ultrasounds Non OB Related

GENERAL TERMS & CONDITIONS

TERMS AND CONDITIONS OF INSURANCE COVER OF THE EUROMED SERIES_-

A – GENERAL PROVISIONS

VALID FOR Euromed Silver, Euromed Gold, Euromed Diamond and Euromed Platinum

§ 1 SCOPE OF INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

The scope of insurance cover shall be based on the terms and conditions of insurance for sickness benefit cover of the EUROMED series (tariff), on the statutory prescriptions, and on any additional agreements that may have been made in writing between the insurance company, the policy holder and the parties entitled to insurance.

§ 2 ELIGIBILITY FOR INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply: -

1. Those entitled to insurance are livings-and natural persons.

2. Persons who at the start of the policy are in need of constant care or mentally ill may not be insured and are not insured, even if premiums have been paid. A person is in need of care if he/she for the most part needs external help in order to manage the tasks of daily life.

§ 3 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

So far as has not been agreed to the contrary, the following shall apply:

1. The framework insurance contract will be concluded in writing between the insurance company and the policy holder, on the basis of these terms and conditions of insurance. The policy holder is entitled, in the context of the insurance contract, to make possible the registration of persons insured in the form of lists as persons liable for premiums with parties entitled to insurance.

2. The policy holder shall be obliged to notify the parties entitled to insurance of the termination of the framework insurance contract within the term of one month after it becomes known.

3. If the business of the policy holder or the party entitled to insurance should fail, the insurance coverage in respect of the person insured(s) remains unaffected by this.

§ 4 START OF INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

1. Insurance cover commences at the time stated in the confirmation document (start of insurance cover), not however before payment of the premium and not before expiry of the waiting period.
2. No benefit will be paid for claims occasioned before the start of insurance.
3. No benefit will be paid for claims occasioned during the waiting period.

§ 5 END OF INSURANCE COVER

1. The maximum duration of insurance cover is defined in terms of the relevant tariff.
2. Insurance cover for individual persons insured comes to an end, even in connection with pending claims, with
 - a) the end of the insurance relationship
 - b) the expiry agreed upon
 - c) deregistration from the group of persons insured by the party entitled to insurance, taking into account the terms of notice and conditions defined in the tariff
 - d) the death of the person insured
 - e) the ending of the framework insurance agreement between the insurance company and the policy holder

§ 6 GENERAL EXCLUSIONS

So far as has not been agreed to the contrary, the following shall apply:

There shall be no obligation to pay benefit

1. on account of such illnesses, including their consequences, or consequences of such accidents as are occasioned by active participation in events of war or civil disturbance, or through professional participation in sporting competitions organised by sporting federations and associations or preparatory measures related to these, or such as are recognised as war injuries and are not explicitly included in the insurance cover.
2. on account of illnesses and accidents caused by deliberate intent, including their consequences, or on account of withdrawal measures including courses of withdrawal treatment.
3. during health resort or sanatorium treatment, or during a course of rehabilitation organised by the party legally responsible for rehabilitation.
4. in consequence of accommodation occasioned by the need of care or custody.
5. for benefits consequent on illnesses, complaints or conditions resulting from accidents which existed at the time of the start of the insurance cover.
6. for the treatment of mental or emotional disturbances, or for hypnosis or psychotherapy.
7. on account of such illnesses, including their consequences, which arise as a result of the person's having neglected to obtain the protective inoculations prescribed by statute, unless there should be medical reasons why protective inoculation cannot be carried out. In this case the medical reasons are to be proved to the insurance company by the submission of a doctor's certificate.
8. on account of birth defects or defects arising from childbirth.
9. on account of HIV and related diseases.

Note: please be aware of the special exclusions in policy wording or Euromed Silver, Euromed Gold, Euromed Diamond and Euromed Platinum.

Coverage of medical expenses, § 3.

§ 7 WAITING PERIOD

The waiting periods agreed upon in the relevant tariff shall apply.

§ 8 PAYMENT OF PREMIUMS

So far as has not been agreed to the contrary, the following shall apply:

1. The premium is an annual premium, which will be made in full. It is determined by the relevant tariff, and is to be paid in advance on conclusion of the insurance contract.
2. The given tariff may allow for payment of premiums by direct debit or by credit card payment. The premium shall then be considered to have been paid when a legally valid authorisation to debit the insured party's account has been issued, so long as it proves possible thereafter to debit the amount effectively.

§ 9 PAYMENT OF INSURANCE BENEFITS

1. The insurance company shall be obliged to pay out benefits only if the original invoices are presented and the required documentary proofs supplied. These then become the property of the insurance company. If the original papers have been presented to another insurance company for reimbursement, duplicates of the invoices will be considered sufficient, provided that the other insurance company has made a note on the document of the benefit paid.

2. All receipts must carry the name of the physician treating the patient, the first name, surname and date of birth of the patient treated, as well as a description of the illness and the dates of treatment. Benefits paid by other insurance companies, or other companies' refusal to pay such benefits, must be shown.

3. Costs that have been incurred in a foreign currency will be converted into Dirhams at the exchange rate of the day on which the receipts are received by the insurance company.

The exchange rate for the day is taken to be that defined by

"Währungen der Welt" ["World currencies"], publications of the Deutsche Bundesbank [German Federal Bank], Frankfurt, in accordance with the most recent level, unless the party insured can prove on the basis of a bank slip that he obtained the foreign currency required for payment of the invoice at a less favourable rate, and that this was caused by a change in the currency valuation.

4. Costs incurred for the payment of insurance benefit by banker's draft to a foreign country, or for special forms of fund transfer which have been selected at the request of the insured party, will be deducted from the benefit paid.

5. Claims to insurance benefit cannot either be assigned or given in pledge.

6. The insurance company shall be entitled to pay out benefit to the party who submits or sends regular documentary proofs, unless the insurance company has any good reason to doubt the bona fides of the party submitting or sending.

Note: please have regard as well to the special conditions for payment of insurance benefit in policy wording of Euromed Silver, Euromed Gold, Euromed Diamond and Euromed Platinum. Insurance for the cost of medical treatment, § 4

§ 10 GENERAL OBLIGATIONS

1. On being requested to do so by the insurance company, the person insured and the party entitled to insurance are to supply any information which may be required in order to establish the facts of the claim or of the insurance company's obligation to pay benefit, as well as the scope of this obligation. The information requested should also be supplied to a person appointed by the insurance company.

2. The person insured is to see to it, as far as possible, that damages shall be minimised, and to refrain from any activities, which are prejudicial to recovery.

3. The person insured and the party entitled to insurance shall be obliged to authorise any reasonable investigations into the occasion and extent of the obligation to pay benefit, in particular and in addition to submit to examination by a doctor appointed by the insurance company, as also to release physicians treating the illness and other insurance companies from their obligation of confidentiality, if required, and in a case of death to submit the death certificate.

4. The person insured and the party entitled to insurance are to inform the insurance company without delay of any changes of address (domestic residence, place of business or place of commercial operations). Otherwise written declarations which are sent by the insurance company in the form of a registered letter to the last known address shall be considered as having been effectively delivered.

5. In so far as in the given country of residence particular stipulations, proceedings or legal regulations apply to the processing of insured damages, these may be incorporated by the insurance company (on receiving the relevant information) or by the party entitled to insurance so as to form an integral part of these terms and conditions of insurance.

6. The insurance company is to be informed of a case of pregnancy within four weeks after the existence of a pregnancy has been established, unless defined otherwise in terms of the relevant tariff.

Note: please have regard as well to the Special Obligations in policy wording of Euromed Silver, Euromed Gold, Euromed Diamond and Euromed Platinum. Coverage of medical expenses, § 5.

§ 11 CONSEQUENCES OF FAILURE TO ADHERE TO OBLIGATIONS

1. If there should be a failure to adhere to an obligation incumbent on the person insured after the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit, unless it should be the case that the failure to adhere to the obligation was not the result either of deliberate intent or of gross negligence.

In a case where an obligation has been breached out of gross negligence, the insurance company shall remain obliged to pay benefit to the extent that the breach shall have had no implications either for the establishment or for the scope of the obligation incumbent on the insurance company.

2. Knowledge and responsibility on the part of the person insured are to be taken as equivalent to knowledge and responsibility on the part of the party entitled to insurance.

§ 12 CLAIMS AGAINST THIRD PARTIES

1. If the party entitled to insurance or a person insured should have indemnification claims against third parties, the nature of which have nothing to do with the legal conditions of the insurance policy, then an obligation shall exist, without regard to the statutory transference of claims as defined by § 67 of the VVG¹, to assign these claims in writing to the insurance company up to the amount of benefit that is to be paid on the basis of the insurance contract.

2. If the party entitled to insurance or a person insured resigns such a claim or a right that serves to ensure the claim without the consent of the insurance company, the latter shall be released from the obligation to pay benefit to the extent that it would have been able to obtain compensation on the basis of the right or claim surrendered.

§ 13 ADJUSTMENT OF PREMIUM AND BENEFIT RATES / INSURANCE YEAR

1. The insurance company shall be entitled to make changes in the premium level or the extent of the benefits at the beginning of a new insurance year, provided that it notifies the policy holder of this with a term of notice of three months.

2. The insurance year will be defined in the terms and conditions of the EUROMED series, -

3. The policy holder shall be obliged to give the party entitled to insurance written notice of an adjustment of the premium level or of the level of benefits paid within a term of three weeks from the time it is made known.

§ 14 OFFSET CHARGES

The policy holder, party entitled to insurance and person insured may only set off amounts to which they are entitled against claims of the insurance company to the extent that the counter-claim is either uncontested or has been established as valid at law.

§ 15 DUE DATE OF BENEFIT PAYMENT / TERM FOR SUIT TO BE BROUGHT

¹ Versicherungsvertragsgesetz: Insurance Contract Law.

1. Once the obligation to pay benefit on the part of the insurance company has been proved, with reference both to the grounds and the amount, the insurance benefits must be paid out within one month.

2. If the insurance company has rejected a claim, either with reference to the grounds or to the amount, it shall be released from the obligation to pay benefit, if the claim of the policy holder has not been upheld as valid at law within a period of six months. The term shall not be considered to have begun until the insurance company has refused to acknowledge the claim in writing, giving notice of the associated legal consequences that will follow from the expiry of the term.

§ 16 RIGHTS AND OBLIGATIONS IN CASE OF DAMAGES OCCURRING

The person insured has an intrinsic right to assert claims based on the contract against the insurance company.

§ 17 DECLARATIONS OF INTENTION AND NOTIFICATIONS

Declarations of intention and notifications to the insurance company require to be expressed in writing. Intermediate insurance agents are not authorised to receive these.

§ 18 RESPONSIBLE COURT

Suit may be brought against the insurance company at the main place of business of the policy holder.

§ 19 APPLICABLE LAW / RESPONSIBLE SUPERVISORY AUTHORITY

The insurance relationship shall be subject to The laws of United Arab Emirates. The responsible supervisory authority for complaints is the Ministry of Economy & Commerce, Abu Dhabi, United Arab Emirates.

B – SPECIAL PROVISIONS

THE RELEVANT SECTION APPLIES IN DEPENDENCE ON THE INSURANCE COVER SELECTED

SECTION I. COVERAGE OF MEDICAL EXPENSES

§1 OBJECT OF INSURANCE

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company shall offer insurance cover for illnesses, sicknesses, accidents and other events mentioned in the contract either within United Arab Emirates or abroad. In case of a claim occurring, it will reimburse expenses in connection with medical treatment and other benefits agreed upon.

2. Grounds of a claim shall be the medically necessitated treatment of a person insured on account of illness or in consequence of an accident. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that there is no further need of treatment.

3. In so far as the tariff defines the relevant benefits, further grounds for a claim shall also be:

- a) Examination and medically necessitated treatment in connection with pregnancy and childbirth
- b) Examination as an outpatient, with a view to the early recognition of illness in accordance with statutory programmes that have been introduced (targeted prophylactic examinations)
- c) Death

4. Insurance cover shall extend to medical treatment in the country of residence.

§ 2 SCOPE OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The nature and amount of the insurance benefits shall be derived from the terms and conditions of insurance of the Euromed series,

2. The person insured has the liberty to choose from approved doctors/ clinics/ hospitals or medical establishments as per the network of the Third Party Administrator or from among the doctors, dentists, medical practitioners or medical establishments who are qualified to give treatment in terms of the law that applies to the country of residence covered by the terms of the insurance policy. However, treatment taken from doctors/clinics/other medical establishments who do not fall in the network of the Third Party Administrator within UAE will be strictly on reimbursement basis, subject to self insurance as under

1- Euromed Silver	- 40%
2- Euromed Gold	- 35%
3- Euromed Diamond	- 30%
4- Euromed Platinum	- 20%

3. Pharmaceuticals, bandages, medicines and medical aids must be prescribed by the qualified practitioners mentioned in section 2. Pharmaceuticals may also be obtained from a pharmacy from the network of the Third Party Administrator. Such purchases outside the network within UAE will be subject to self-insurance as stated in point No. 2

4. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possesses sufficient diagnostic equipment and conduct case histories. However, treatment in hospitals outside the UAE network of the Third Party Administrator will be covered on reimbursement basis, subject to self insurance as stated in point No. 2

5. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of § 2, section 4, benefits at the agreed rate will only be paid if the insurance company has given written consent to this before the start of the

treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.

6. The insurance company will pay benefit to the extent defined by the contract for examination and treatment methods and pharmaceuticals that are generally recognised by school medicine. It will in addition pay benefit for methods and pharmaceuticals which have proved themselves in practice to be equally likely to achieve success; the insurance company may however reduce the level of benefit to the amount that would have been paid if existing school medicine methods or pharmaceuticals had been used.

§ 3 SPECIAL EXCLUSIONS

So far as has not been agreed to the contrary, the following shall apply:

1. There shall be no obligation to pay benefit

a) for treatments by doctors, dentists, medical practitioners or in licensed hospitals the invoices for which the insurance company has excluded from reimbursement on good grounds, if the claim occurs after the party entitled to insurance has been notified of this exclusion of benefit. In so far as at the time of notification a claim should be pending, no obligation to pay benefit shall exist for expenses incurred after the expiry of three months from the time of notification being given.

b) during a stay in a spa or health resort, even if this involves a stay in hospital. This limitation shall no longer apply if the person insured has his/her constant place of residence there or if he/she becomes unable to work as a result of a sickness independent of the purpose of his/her visit or as a result of an accident that has occurred there, so long as this results, on medical testimony, in his/her being unable to journey home. This limitation also shall no longer apply if and to the extent that the insurance company has given written consent to benefit being paid before the start of residence abroad.

c) for treatments by spouses, parents, children or persons living together in the immediate domestic circle. Costs of materials will be reimbursed in keeping with the given tariff.

2. If the medical treatment or other measure for which benefit has been agreed upon should exceed the medically necessary limits, or if the remuneration claimed is out of proportion, the insurance company may reduce benefit to an acceptable level.

3. If there should also be a claim on third party benefit providers, the insurance company shall only be obliged to pay benefit for expenses which are necessary in spite of the benefits paid by third parties and which are insured.

§ 4 SPECIAL CONDITIONS FOR THE PAYMENT OF INSURANCE BENEFIT / DOCUMENTARY EVIDENCE TO BE SUBMITTED

1. To prove the medical necessity of return transport, a doctor's certificate, which should clearly demonstrate the medical necessity, must be submitted.

2. For the assertion of claims in connection with conveyance of the body or funeral costs, an official or medical certificate giving the cause of death must be submitted.

§ 5 SPECIAL OBLIGATIONS

1. The insurance company is to be notified of any hospital treatment within ten days from its starting.

2. The person insured must submit the relevant documentary evidence to the insurance company within three months from the time of each individual course of treatment.

3. If a person insured has concluded a contract for the insurance of medical expenses with another insurance company, if such exists or a person insured avails himself/herself of the entitlement to insurance in connection with statutory health insurance cover, the party entitled to insurance or the person insured shall be obliged to notify the insurance company without delay of the other insurance cover arranged.

GENERAL NOTE: EXTRACT FROM THE VVG

§ 6 FAILURE TO ADHERE TO AN OBLIGATION

1. If the contract stipulates that, in case of a breach of an obligation which is owed by the person insured to the insurance company before the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit, the legal consequence agreed to shall not be effective if the breach was to be seen as one for which the party could not be held responsible. The insurance company may give notice of termination of the contract within one month from the time when the breach comes to its knowledge, without observing a term of notice, unless the breach is to be seen as one for which the party could not be held responsible. If the insurance company does not give notice of termination of the contract within one month, it may not avail itself of the release from obligation to pay benefit that has been agreed upon.

2. If there has been a failure to adhere to an obligation which the policy holder owes to the insurance company with a view to the reduction of the risk or to guard against any possible increase in the risk, the insurance company may not avail itself of the release from obligation to pay benefit which has been agreed upon if it be the case that the breach of obligation has not had any effect on the occurrence of a claim or on the scope of the associated benefit due.

3. If the contract stipulates a release from the obligation to pay benefit in a case where the person insured fails to adhere to an obligation which is owed to the insurance company after the occurrence of the claim, the legal consequence agreed upon shall not be effective if the breach in question was not the result of either deliberate intent or gross negligence. In a case of gross negligence the insurance company shall remain obliged to pay benefit to the extent that the breach involved shall have had no effect either on the establishment of the claim or on the establishment of the scope of the benefit which it is incumbent on the insurance company to pay.

4. Any agreement according to which the insurance company shall be entitled in case of a breach of obligation to withdraw from the contract is invalid.

§ 11 DUE DATE OF PAYMENT

1. Cash payments are to be made by the insurance company with the ending of the enquiries that are needed for the establishment of the claim and the scope of the benefit payable by the insurance company.

2. If these enquiries are not completed after the expiry of one month from the time of notification of the claim, the policy holder shall be entitled to request advance payment on the total claim in the form of instalment payments to the amount of the sum which would be the minimum that the insurance company would have to pay in the given circumstances.

3. This term shall not apply so long as the conclusion of the enquiries has been held up in consequence of actions for which the policy holder can be held responsible.

4. Any agreement by which the insurance company is released from the obligation to pay interest on arrears is invalid.

§ 12 EXPIRY BY LIMITATION

1. The claims based on the insurance contract shall be subject to expiry by limitation after two years. The period of limitation shall begin with the close of the year in which payment of the benefit may be requested.

2. If the insurance company has been notified of a claim by the policy holder, expiry by limitation shall be blocked until the receipt of the written decision of the insurance company.

3. The insurance company shall be released from the obligation to pay benefit if the claim to benefit has not been successfully asserted at law within six months. This term does not begin until the time when the insurance company has declined in writing to recognise the claim that has been asserted by the policy holder, stating the legal consequences that will follow from the expiry of the term.

§ 38 DELAYED PAYMENT OF THE FIRST ANNUAL PREMIUM

1. If the first annual premium is not paid on time, the insurance company shall be entitled, so long as payment has not been effected, to withdraw from the contract. It shall count as grounds for withdrawal if the claim to the premium has not been successfully asserted at law within three months from the due date of payment.

2. If the premium has not yet been paid at the time of the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit.

§ 39 DELAYED PAYMENT OF A SUBSEQUENT RENEWAL PREMIUM

1. If a subsequent premium is not paid on time, the insurance company may at the cost of the policy holder appoint to the latter in writing a term of payment of at least two weeks; for signature purposes, a reproduction of the autograph signature shall be taken as sufficient. In this connection the legal consequences are to be stated which will ensue with the expiry of the term, in keeping with sections 2 and 3. Any appointment of a term that fails to take these prescriptions into account is invalid.

2. If a claim should occur after the expiry of the term, and if the policy holder should be in arrears with the payment of the premium or the interest or costs owing on it, the insurance company shall be released from the obligation to pay benefit.

3. After the expiry of the term, if the policy holder is in arrears with the payment, the insurance company may give notice of termination of the insurance contract without observance of any term of notice. Termination may be effected already at the time of the appointment of a term for payment, in such a way that it becomes effective on the expiry of the term, if the policy holder at this point is in arrears with the payment; the policy holder must be expressly informed of this when notice of termination is given. The effects of the notice of termination lapse if the policy holder makes good the payment within one month after notice of termination has been given, or, if notice of termination has been associated with the appointment of a term for payment, within one month after the expiry of the term set for payment, provided that a claim has not arisen by this time.

4. In so far as the legal consequences indicated in sections 2 and 3 relate to the fact that interest or costs have not been paid, they shall only become effective if the notification of the term set for payment states the rate of interest or the amount of the costs.

§ 67 ASSIGNMENT OF INDEMNIFICATION CLAIMS

1. If the policy holder has an indemnification claim against a third party, the claim shall be assigned to the insurance company, provided that the latter indemnifies the policy holder. The transfer may not be claimed to the disadvantage of the policy holder. If the policy holder surrenders his claim on the third party or a right that serves to ensure the claim, the insurance company shall be released from its obligation to indemnify the policy holder to the extent that it could have obtained compensation from the claim or right in question.

2. If the policy holder's claim to indemnification is directed to a family member living with him/her in a domestic context, such an assignment is excluded; the claim shall however be assigned if the family member should have occasioned the damage by acting with deliberate intent.