Gjensidige

HEALTH INSURANCE TERMS AND CONDITIONS NO. 067

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Contents

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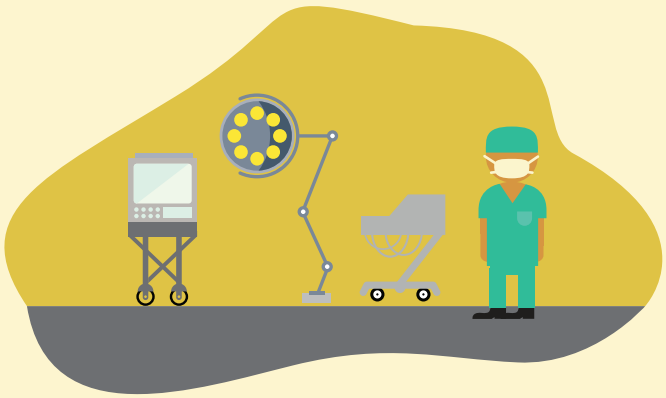


I. Health Insurance Conditions

APPROVED by:
Gjensidige ADB
Upon the Decision of the Board Meeting of 27 November 2020.
Terms and Conditions entered into force since 9 March 2020.

1. Terms and Definitions

If the definitions provided for in these Health Insurance Terms and Conditions and General Insurance Terms and Conditions differ, definitions stipulated in these Health Insurance Terms and Conditions shall prevail. Concepts and definitions not provided in these Health Insurance Terms and Conditions shall be understood in a way they are defined in General Insurance Terms and Conditions.

1.1. **You** or **Policyholder** means a natural person specified in the insurance certificate whose property interests are insured by the Health Insurance Contract.
1.2. **Outpatient surgery service** is a scheduled curative health care service the provision of which may involve local or regional anesthesia, executed by the operating or procedure executing doctor, after which the post-operative (post-procedure) care of the patient and the possibility to provide him with health care services are ensured without taking the patient out of his normal social environment.
1.3. **Diagnostics** means doctor's consultations, diagnostic tests, and diagnostic procedures executed in order to diagnose, research or supervise the illness.
1.4. **Day surgery service** - a scheduled personal health care service during which a curative and/or diagnostic intervention procedure is executed. The duration of the service may not exceed one bed-day.
1.5. **Day inpatient service** - scheduled curative and/or diagnostic personal health care activity during which the patient is supervised for up to 8 hours.
1.6. **Policyholder** - means a person who has applied to Us for conclusion of an insurance contract, or who has received an offer from Us to conclude an insurance contract, or who has concluded an insurance contract with Us.
1.7. **We,** or **the Insurer** - ADB "Gjensidige".
1.8. **Treatment** means doctor's consultations, diagnostic tests, diagnostic and therapeutic procedures for the treatment of the disease.
1.9. **Long-term** care means permanent, long-lasting care for the elderly, disabled people and patients with chronic diseases, or after chronic diseases and the consequences they caused, including services at home, nursing care institution, medical center, and social welfare institution.
1.10. **Medical aid measures** means bandages, patches, syringes, drip systems, splint systems, human's movement system prosthetic systems, sticks, and crutches
1.11. **Medical device** means a product with the help of which a human disease can be diagnosed, treated, or its progress monitored; furthermore, it can help to identify, treat or compensate the human's trauma or disability.
1.12. **Alternative medicine** means diagnosis, treatment or prevention of medical conditions using non-traditional medical methods not approved in the Republic of Lithuania, such as: acupuncture, ozone therapy, leech therapy, bio resonance diagnostics, phytotherapy, hydrocollonotherapy, osteopathy, homeopathy, reflexotherapy, aromatherapy.
1.13. **Partner** is an institution, company, and organization which has concluded cooperation agreement with us, whereby it rendered services and/or sold goods to You in accordance with the conditions of the aforementioned cooperation agreement.
1.14. **Health disorder** means medically diagnosed acute or chronic disease or injury for which You have expressed complaints, and which requires diagnostic or therapeutic treatment.
1.15. **Trauma** means damage to Your tissue wholeness that occurred at a specific time and at a specific place due to a sudden, unexpected physical, chemical, or thermal environmental effect which caused hindering the functions of parts of the body and/or the functioning of body organs. Damage to health caused by degenerative changes shall not be considered trauma.

2. Insurance object

2.1. Object of insurance means your property interests and You related to the insured events provided for in the insurance risks selected by the Policyholder and specified in the insurance certificate as assumed by us.
2.2. In all cases, object of insurance is related to the following:
2.2.1. Health care services provided to You or goods purchased due to Your health problems that require diagnostics or application of treatment;
2.2.2. Services provided to You or goods purchased for disease prevention and wellness services.
2.3. A voluntary health insurance is a supplementary insurance, whereby We take an obligation to indemnify your expenses which are not indemnified from the budget of the Compulsory Health Insurance Fund (hereinafter referred to as CHIF) funds. We can indemnify the expenses indemnified from CHIF budget funds but in such case after payment of the insurance benefit. We shall obtain a right to require an indemnity of these expenses from CHIF budget funds

3. Insurance risks

3.1. Upon these Terms and Conditions and Terms and Conditions provided in the insurance certificate, all or some of the following pecuniary risks may be insured:

a) "Outpatient treatment" (Chapter 4);
b) "Inpatient treatment" (Chapter 5);
c) "Prenatal care and childbirth" (Chapter 6);
d) "Dentistry" (Chapter 7);
e) "Medicines and medical supplies" (Chapter 8);
f) "Vitamins and dietary supplements" (Chapter 9);
g) "Optics" (Chapter 10);
h) "Prophylaxis" (Chapter 11);
i) "Medical rehabilitation" (Chapter 12);
j) "Wellness" (Chapter 13);
k) "Critical disease insurance" (Chapter 14);
l) "Various risks insurance" (Chapter 15);

3.2. **Under mutual agreement between Us and the Policyholder, the insurance contract may also insure other insurance risks not provided for in these Terms and Conditions. Such agreement shall be clearly expressed and specified in the insurance certificate.**
3.3. We shall be liable only for those insured events which are provided in the insurance certificate.

4. Outpatient treatment

4.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to outpatient treatment are provided to the Policyholder as a result of the insured event.
4.2. Insured events.
The insured event shall be considered Your health disorder during the insurance contract period which requires health care services.
4.3. In accordance with the **Outpatient treatment** risk in case of an insured event, We indemnify losses (expenses) for:
4.3.1. Ambulance services;
4.3.2. Doctor consultations;
4.3.3. Doctor visits to homes;
4.3.4. Diagnostic tests prescribed by a doctor (laboratory, instrumental);
4.3.5. Prescribed nursing services (i.e. injection of medication, blood collection, wound dressing);
4.3.6. Psychotherapy treatment provided by a psychotherapist (up to 12 times per insurance period);
4.3.7. Prescribed surgery services (including anesthesia, nursing and medical devices).
4.3.7.1. Outpatient surgery services under an applied list of outpatient surgery services approved by the Ministry of Health of the Republic of Lithuania (hereinafter referred to as MOH);
4.3.7.2. Day surgery services under an applied list of day surgery services approved by MOH.
4.3.8. Day inpatient services prescribed by a doctor under an applied list of day inpatient services approved by MOH;
4.4. Expenses for the services specified in paragraphs 4.3.2, 4.3.4-4.3.8 shall be indemnified for only in case they have been provided in an institution having a health care institution license.
4.5. According to the **Outpatient treatment** risks We shall not indemnify the following expenses:
4.5.1. Services provided (goods purchased) which are indemnified under other insurance risks: inpatient personal health care services; care of pregnant women, childbirth and post-natal care; eye correction surgery; jaw surgery; medical rehabilitation, wellness, dentistry; medicines for continuous procedures and intended for the treatment at home (including medicines for the treatment of specific immunotherapy), other medical supplies; optician's products, etc.:
4.5.2. Services provided in paragraphs 17.1-17.2.

5. Inpatient treatment

5.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to inpatient treatment are provided to the Policyholder or goods are purchased as a result of the insured event.
5.2. While concluding the insurance contract, the Policyholder may choose from the following two insurance risk options:
5.2.1. "Inpatient treatment in public hospitals";
5.2.2. "Inpatient treatment in both public and private hospitals".
5.3. Insured events.
The insured event shall be considered Your health disorder which requires health care services and goods.
5.4. In accordance with the **Inpatient treatment** risk in case of an insured event, We indemnify losses (expenses) for:
5.4.1. a paid ward and diagnostic, treatment services, medical supplies, devices, medicines, vitamins, and dietary supplements, if the variant "Inpatient treatment in public hospitals" was selected by You;
5.4.2. a paid ward and diagnostic, treatment services, medical supplies, devices, medicines, vitamins, and dietary supplements, if the variant "Inpatient treatment in both public and private hospitals" was selected by You;
5.4.3. Expenses for the services specified in paragraph 5.4.1 shall be indemnified for only in case they have been
5.4.4. Expenses for the services specified in paragraph 5.4.2 shall be indemnified for only in case they have been provided in an state (public) or private institution having a health care institution license.
5.5. According to the **Inpatient treatment** risks We shall not indemnify the following expenses:
5.5.1. Services provided (goods purchased) which are indemnified under other insurance risks: outpatient personal health care services; care of pregnant women, childbirth and post-natal care; eye correction surgery; jaw surgery; medical rehabilitation, wellness, dentistry; medicines for intended for the treatment at home, other medical supplies, etc.;
5.5.2. Endoprosthesis;
5.5.3. Services (goods) provided in paragraphs 17.1-17.2.

6. Prenatal care and childbirth

6.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to prenatal care and childbirth are provided to the Policyholder as a result of the insured event.
6.2. Insured events.
The insured event shall be considered Your pregnancy during the insurance contract period which requires health care services.
6.3. In accordance with the **Prenatal care and childbirth** risk in case of an insured event, We indemnify losses (expenses) for:
6.3.1. Consultations of a general practitioner or a doctor obstetrician (obstetrician-gynecologist);
6.3.2. Consultation from other doctors-specialists related to pregnancy;
6.3.3. Diagnostic (laboratory, instrumental) tests prescribed by a general practitioner, by a doctor obstetrician (obstetrician-gynecologist) or by other doctors-specialists;
6.3.4. Childbirth service, post-natal care and paid ward during laboring;
6.3.5. Expenses for the services specified in paragraphs 6.3.1-6.3.4 shall be indemnified for only in case they have been provided in an institution having a health care institution license.
6.4. According to **Prenatal care and childbirth** risks We will not indemnify the following expenses:
6.4.1. Services provided (goods purchased) which are indemnified under other insurance risks: eye and jaw surgery; health promotion, medical rehabilitation, dentistry; medicines for continuous procedures and treatment at home, medical supplies, vitamins, dietary supplements and other pharmaceutical goods; optician's products, etc.;
6.4.2. Services provided in paragraphs 17.1-17.2.

7. Dentistry

7.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to teeth, jaws treatment and prophylaxis are provided to the Policyholder as a result of the insured event.
7.2. Insured events.
The insured event shall be considered Your teeth (jawbone) disease or the injury resulting from the trauma and dental disease prevention services, due to which You need a personal healthcare service.
7.3. In accordance with the **Dentistry** risk in case of an insured event, We indemnify losses (expenses) for:
7.3.1. Oral hygiene procedures;
7.3.2. Services of X-ray test and dental filling, also, services of endodontic, periodontal and surgical dental disease treatment;
7.3.3. Dental prosthetics, dental implantation and orthodontic treatment services;

7.3.4. Expenses for the services specified in paragraphs 7.3.1-7.3.3 shall be indemnified only in case they have been provided in an institution having a dentistry care institution license.
7.4. According to the **Dentistry** risks We shall not indemnify the following expenses:
7.4.1. Services provided (goods purchased) which are indemnified under other insurance risks: medicines, other medical products, etc.;
7.4.2. Aesthetic dental services (except for aesthetic filling);
7.4.3. Services provided in paragraphs 17.1.1-17.1.2, 17.2.1-17.2.5, 17.3.3.

8. Medicines and medical supplies

8.1. These insurance risks are intended to protect You against possible pecuniary losses when goods related to outpatient treatment are purchased for the Policyholder as a result of the insured event.
8.2. Insured events.
The insured event shall be considered Your health disorder which requires health care goods.
8.3. According to the **Medicines and medical supplies** risk, in an insured event We indemnify losses (expenses) for:
8.3.1. Medical products and medical supplies (see the definition "Medical supplies") prescribed by the doctor in the prescription;
8.3.2. If medicines and/or medical supplies are indemnified from the Compulsory Health Insurance Fund budget, the surcharge shall be indemnified by 100%.
8.3.3. Expenses for the goods specified in paragraph 8.3.1 shall be indemnified only in case they have been purchased in the pharmacy (e-pharmacy).
8.4. According to the **Medicines and medical supplies** risk We shall not indemnify the following expenses:
8.4.1. For Services provided (goods purchased) which are indemnified under other insurance risks: other medical products, optician's products, etc.;
8.4.2. for the services (goods) specified in paragraphs 17.1.1-17.1.2, 17.2.3, 17.3.

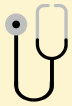
9. Vitamins and dietary supplements

9.1. These insurance risks are intended to protect You against possible pecuniary losses when goods related to health treatment and prevention are purchased for the Policyholder as a result of the insured event.
9.2. Insured events.
The insured event shall be considered Your health disorder or the prophylaxis of your diseases which require health care goods.
9.3. In accordance with the **Vitamins and dietary supplements** risk in case of an insured event, We indemnify losses (expenses) for:
9.3.1. Vitamins and dietary supplements;
9.3.2. Non-prescription medicines;
9.3.3. Expenses for the goods specified in paragraphs 9.3.1-9.3.2 shall be indemnified only in case they have been purchased in the pharmacy (e-pharmacy).
9.4. In accordance with the **Vitamins and dietary supplements** risk in case of an insured event, We do not indemnify for losses for:
9.4.1. Services provided (goods purchased) which are indemnified under other insurance risks: other medical products, medical devices, etc.;
9.4.2. The services (goods) specified in paragraph 17.1.1.

10. Optics

10.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to eye diseases treatment are provided to the Policyholder or goods are purchased as a result of the insured event.
10.2. Insured events.
The insured event shall be considered Your eye disease which requires goods and services.
10.3. In accordance with the **Optics** risk in case of an insured event, We indemnify losses (expenses) for:
10.3.1. Optometry services;
10.3.2. Corrective glasses or glass lenses prescribed by an ophthalmologist or an optometrist;
10.3.3. Contact lenses prescribed by an ophthalmologist or an optometrist;
10.3.4. Corrective eye surgery prescribed by the doctor;
10.3.5. Expenses for the goods specified in paragraphs 10.3.2-10.3.3 shall be indemnified only in case they have been purchased at the optician's or specialized contact lenses online store;
10.3.6. Expenses for the services specified in paragraph 10.3.4 shall be indemnified for only in case they have been provided in an institution having a health care institution license.
10.4. According to the **Optics** risks We shall not indemnify the following expenses:
10.4.1. Services provided (goods purchased) which are indemnified under other insurance risks:
10.4.2. Diopter-free glasses (e.g. sunglasses, for work with a computer, or driving);
10.4.3. Eyeglasses care products and accessories (e.g. glasses cases and cleaners)
10.4.4. Services provided in paragraphs 17.1.1-17.1.2, 17.2.1-17.2.5.

11. Prophylaxis



11.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to disease prevention, early diagnostics and vaccination are provided to the Policyholder as a result of the insured event.
11.2. While concluding the insurance contract, the Policyholder may choose from the following two insurance risk options:
11.2.1. "Prophylaxis"
11.2.2. "Prophylaxis and vaccination".
11.3. Insured events.
The insured event shall be considered Your disease prevention which requires health care services.
11.4. In accordance with the **Prophylaxis** risk in case of an insured event, We indemnify losses (expenses) for:
11.4.1. Health care services under a valid list of preventive health check types (of employees, drivers, etc.) approved by MOH and for health care services under applied preventive programs approved by MOH (cardiovascular disease prevention program, early diagnosis program of prostate cancer, etc.), personal health care services according to personal health care institution formed health check programs and personal health care services (consultations and diagnostic tests), when the insured did not have any complaints regarding the health condition, has executed diagnostic tests without prescription by a doctor or at his own will, if You have chosen the variant "Prophylaxis";
11.4.2. Services provided in paragraph 11.4.1 and additionally for the doctor's consultation regarding vaccination, the vaccine of Your choice and vaccination services if You have chosen the "Prophylaxis and vaccination" variant;
11.4.3. Expenses for the services specified in paragraphs 11.4.1-11.4.2 shall be indemnified for only in case they have been provided in an institution having a health care institution license.
11.5. According to the **Prophylaxis** risks We shall not indemnify the following expenses:
11.5.1. Services provided (goods purchased) which are indemnified under other insurance risks: care of pregnant women, childbirth and post-natal care; wellness services, medical rehabilitation, dentistry, medicines, other medical supplies; optician's products, etc.;
11.5.2. Services provided in paragraphs 17.1.1-17.1.2, 17.2.4-17.2.5.

12. Medical rehabilitation

12.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to medical

rehabilitation treatment are provided to the Policyholder as a result of the insured event.

12.2. Insured events.
The insured event shall be considered Your health disorder which requires medical rehabilitation services.

12.3. In accordance with the **Medical rehabilitation** risk in case of an insured event, We indemnify losses (expenses) for:

12.3.1. Physiotherapy procedures;
12.3.2. Kinesitherapist services and Kinesitherapy procedures;
12.3.3. Electro-impulse therapy procedures;
12.3.4. Occupational therapy;
12.3.5. Mud and water treatments;
12.3.6. Therapeutic massages;
12.3.7. Halotherapy;
12.3.8. Manual therapy.

12.3.9. Expenses for the services specified in paragraphs 12.3.1-12.3.8 shall be indemnified for only in case they have been provided in an institution having a health care institution license.

12.4. According to the **Medical rehabilitation** risks We shall not indemnify the following expenses:

12.4.1. Services provided (goods purchased) which are indemnified under other insurance risks: wellness services, dentistry, prophylaxis; medical supplies, medical devices, vitamins, dietary supplements, other pharmaceutical goods; optician's products, etc.;

12.4.2. Services provided in paragraphs 17.1-17.2.

13. Wellness

13.1. These insurance risks are intended to protect You against possible pecuniary losses when services related to disease prevention or body strengthening.

13.2. Insured events.
The insured event shall be considered Your disease prevention (health promotion) which requires services.

13.3. In accordance with the **Wellness** risk in case of an insured event, We indemnify losses (expenses) for:

13.3.1. Training in the gym, aerobics, yoga, tennis, badminton, squash, fitness, callanetics, pilates, and swimming, as well as other types of sport;
13.3.2. All kinds of massages, mud and water treatments, physiotherapy, kinesitherapy;
13.3.3. Psychologist's consultations;
13.3.4. Homeopath services;
13.3.5. Alternative (non-traditional) medical services.

13.3.6. Expenses for the services provided in paragraphs 13.3.1-13.3.5 shall be indemnified only in case if the services are provided in institutions having a health care institution license and/or sanatoriums and/or gyms and/or swimming pools and/or tennis (squash) courts and/or SPAs (except for the health promotion is provided by the person acting under the individual activity certificate).

13.3.7. Your expenses for the services provided in paragraph 13.3 shall also be indemnified when they are provided by the person acting under the individual activity certificate.

13.4. According to the **Wellness** risks We shall not indemnify the following expenses:

13.4.1. Services provided (goods purchased) which are indemnified under other insurance risks: dentistry, medicines, other medical products, optician's products, etc.;

13.4.2. Services provided in paragraphs 17.1.1-17.1.4 and cosmetic (beauty) procedures (part of paragraph 17.2.6).

14. Critical disease insurance

14.1. This insurance risk is intended for Your protection against possible pecuniary losses related to a diagnosed critical illness and its treatment.

14.2. While concluding the insurance contract, the Policyholder may choose from the following two insurance risk options:

14.2.1. "Treatment of critical illness in public hospitals";
14.2.2. "Lump indemnity in case of a critical disease".

14.3. Insured events.
The insured event shall be considered a critical disease diagnosed to You for the first time in Your life. The list of critical diseases and the criteria for confirmation of these diseases as insured events, the compliance of which is mandatory for the disease confirmation as an insured event, are provided in Annex 1 of these Terms and Conditions.

14.4. In accordance with the **Critical disease insurance** risk in case of an insured event, We indemnify (pay the benefit) losses (expenses) for:

14.4.1. Treatment of diagnosed critical illness, if You have chosen the option "Treatment of critical illnesses in state hospitals";

14.4.2. The whole amount of sum insured shall be paid once per period of the insurance contract, regardless of the number of the critical diseases diagnosed to you, if You have chosen the option "Lump indemnity in case of a critical disease".

14.5. According to the **Critical disease insurance** risk We shall not indemnify the following expenses:

14.5.1. Services provided (goods purchased) which are indemnified under other insurance risks: wellness, rehabilitation, dentistry; medicines intended for home treatment, other medicines and other medical products, etc.;
14.5.2. Diagnosed diseases not included into the List of Critical Diseases (Annex 1 of the Terms and Conditions);
14.5.3. Services (products) provided in paragraphs 17.1, 17.2.1-17.2.5 and cosmetic (beauty) procedures (part of paragraph 17.2.6).

15. Insurance of various risks

15.1. This insurance risk is intended to protect You against possible pecuniary losses when the services specified in Chapters 4-13 are provided or goods are purchased as a result of the insured event.

15.2. While concluding the insurance contract, the Policyholder may choose from the following two insurance risk options:

15.2.1. "Insurance of various risks";
15.2.2. "Medical insurance of various risks".

15.3. Insured events.
The insured event shall be considered Your health disorder or Your disease prevention (health promotion) which requires goods and services.

15.3.1. If You have chosen the option **"Insurance of various risks"**, in case of the insured event We shall indemnify the expenses for:

a) Services provided in outpatient and inpatient personal health care institutions;
b) Services provided in an institution having a dentistry care institution license;
c) The following products purchased in pharmacies: medicines and medical assistance measures, vitamins, dietary supplements, medical devices, hygiene products and therapeutic cosmetics;
d) Services (products) provided (purchased) at the optician's or special online contact lenses shops;
e) Services provided in gyms, swimming pools, tennis (squash), courts, SPAs or sanatoriums.
f) Psychologist's consultations;
g) Homeopathic and alternative (non-traditional) medicine services.

15.3.2. If You have chosen the option **"Medical insurance of various risks"**, in case of the insured event We shall indemnify the expenses for:

a) Services provided in outpatient and inpatient personal health care institutions;
b) Services provided in an institution having a dentistry care institution license;
c) Medicines and medical assistance measures, dietary supplements and vitamins, as well as medical devices purchased in the pharmacies;
d) Items purchased at optician's or specialized online contact lenses shops: corrective glasses or eyeglass lenses, contact lenses;

15.3.3. If You have chosen the option **"Insurance of various risks"**, We shall not indemnify the expenses for the services provided in paragraphs 17.1.1-17.1.3.

15.3.4. If You have chosen the option **"Medical insurance of various risks"**, We shall not indemnify expenses for the following:

a) Services (goods), provided for in paragraphs 17.1.1-17.1.3, 17.2.4, cosmetic (beauty) procedures (part of paragraph 17.2.6) and 17.3.2 and services provided in an institution, that has no health care institution license.
b) Diopter-free glasses (e.g. sunglasses, for work with a computer, or driving);
c) Eyeglasses care products and accessories (e.g. glasses cases, solutions and cleaners);
d) Sports services;
e) Wellness services (except medical rehabilitation procedures provided by a institution having a personal health care institution license).

16. Non-insured events

16.1. The following are considered to be non-insured events for any insurance risk, the health disorders, taking place due:
16.1.1. When You commit suicide or intentionally injure yourself;
16.1.2. due to intentional actions of the Policyholder or You;
16.1.3. In the case of acts performed by You that are considered a criminal offense or an administrative offense under the laws of the Republic of Lithuania or the state in which they are conducted (except for traffic offenses); also arising out of the detention of You for such acts;
16.1.4. due to your intoxication with alcohol, drugs or other intoxicating substances;
16.1.5. due to the actions of foreign enemies, military action (regardless of the declaration of martial law), civil war, coup or usurpation, mass unrest, insurrection, revolution, rebellion, terrorist activity;
16.1.6. due to involvement in hostilities, military operations, mass and civil unrest, insurgency, riots, strikes;
16.1.7. due to restrictions imposed by authorities, strike, riots, mass unrest, act of terrorism;
16.1.8. due to your abduction or You being a hostage;
16.1.9. due to an atomic explosion, the effects of nuclear power, global catastrophes or natural disasters (earthquake, hurricane, tsunami, etc.); pandemics, ecological disasters, chemical contamination.
16.2. In the case of insurance risk of critical diseases, a critical disease that has been diagnosed to You during the first 2 months of coverage will be considered a non-insured event, except for renewal of insurance contracts without interruption when during a renewal of the insurance contract an insurance risk of critical diseases has been already covered by a pre-existing insurance contract.

17. Uncovered losses

17.1. We shall not indemnify the expenses for the services provided (purchased products):
17.1.1. The services provided (purchased) prior to the coverage enactment or following the insurance coverage validity period;
17.1.2. accommodation and/or catering services;
17.1.3. services, which were provided in water or winter theme parks;
17.1.4. Long-term nursing.
17.2. We shall not indemnify the expenses for the services (personal health care services) provided as follow:
17.2.1. If You applied to a health care institution without any specific complaints on the health condition or on the periodic illness continuation, when there are no signs of the disease getting more acute;
17.2.2. When You did not pre-agree with Us in writing; on the provision of day surgery services or treatment in private hospital in writing;
17.2.3. When treatment is not related to health disorders;
17.2.4. Provided in an institutions and/or by a specialist having no license, permits, stamps or other documentation that is mandatory for providing such services;
17.2.5. Services which are assigned to the alternative medicine (e.g. detoxification, acupuncture, biopsy, phytotherapy, bioresonance diagnostics, intestinal cleansing);
17.2.6. Services (procedures): blood plasma, hyaluronic acid, botulinum injections; stem cell therapy; hemodialysis; artificial insemination; family planning; organ (tissue) transplantation; cosmetic plastic and aesthetic purposes (beauty) procedures and operations; aesthetic dermatology services (phototherapy, photodynamic therapy, impulse light therapy, laser aesthetic procedures (treatment of pigmentation, reddish skin, expanded veins, acne, stretch marks, scars, etc.)); hair removal diagnostics and treatment; nail fungus treatment with laser, contraception matters (including procedures with contraception measures); hair loss diagnostics and treatment, pregnancy termination without medical indications; leg vein procedures (operations), leg vein procedures (operations) when the venous disease according to CEAP classification meets the severity degree C0-C3; vein or capillary disease treatment - sclerotherapy;
17.2.7. Diagnostic tests: allergens; sex hormones (and the ones that regulate their activities) and food intolerance;
17.2.8. For the following diseases, formations, diagnosis and treatment: transmitted sexually (gonorrhea, syphilis, human papilloma virus, syphilis, chlamydiosis, genital herpes, etc.); eyelid operations (compensated only if executed by a doctor ophthalmologist after a computer perimeter research and in case of substantiated clinic indications). oncological diseases, regardless of disease stage (after diagnosis); cancer markers (except cases when prescribed for disease supervision); potency; infertility; AIDS (HIV); moles, warts, pimples, papilloma, condylomas, keratomas, mollusks; addictions; treatment of feet bones, ligaments, tendons, joints and muscles treatment, including foot bone treatment (except for the damage caused by trauma); overweight; nourishment; genetically predisposed illnesses; congenital abnormalities and their complications; genetic research;
17.2.9. a research program prescribed due to any reason is compensated only from the Prophylaxis risk.
17.3. We do not reimburse the cost of following purchased goods:
17.3.1. Medicinal products not registered in accordance with the procedure established by the Law on Pharmacy of the Republic of Lithuania;
17.3.2. Hygiene and cosmetic goods;
17.3.3. Dental guards (athletic, bruxism prevention, whitening, protective, stabilizing).
17.4. We do not indemnify costs for the purchase of group purchase (discount) coupons.

18. Rights and duties

18.1. The Policyholder's duties:
18.1.1. To introduce You with the Terms and Conditions of the insurance contract;
18.1.2. Immediately notify on the changes in a list of the Policyholder events;
18.2. Duties of the Policyholder and You:
18.2.1. Take all reasonable measures available in order to escape the insured event.
18.2.2. In case of the insured event:

a) Take reasonable measures available to mitigate the extent of the damage, also, follow Our instructions in order to avoid emergence of the damage and/or mitigate its extent;
b) Inform us within 30 days about health care services provided and paid by You, disease prevention (health promotion) services or purchased products which We shall indemnify according to the Terms and Conditions of the insurance contract;
c) Provide Us with comprehensive and accurate information on the causes of the insured event, circumstances thereof, extent of damage, documentary evidence of the insured event (original or copies thereof) and all other documents related to the event needed to establish the fact of the insured event and the extent of the damage, or necessary for Us to implement the recourse right to

the person responsible for the damage caused; comply with the lawful demands provided by Us.

d) Store documents evidencing the insured event (if copies of documents have been submitted to Us) for 1 (one year) and provide them on Our demand;

e) When We pursue to verify a presence of the insured event when We require to check health in a personal health care institution indicated by Us.

18.3. Our duties:

18.3.1. Provide the Policyholder with the information on Our name, type of the insurance company, address, Our unit or Our representative' s address (if the insurance contract is concluded not at Our office), procedure of the resolution of the dispute arising from insurance contracts or disputes related to them, possible case of risk increase, Our behavior when the Policyholder and/or You breach the Terms and Conditions of the insurance contract.

18.3.2. At the request of the Policyholder We may specify in the insurance contract or its annexes what part of the insurance premium payable under the insurance contract covers the various insurance risks specified in the insurance contract. However, this exclusion is for information purposes only and does not change the insurance premium payment procedure specified in the insurance contract. We do not accept responsibility for the execution of the tax obligations of the Policyholder/Insured and the responsibility for all and any negative tax consequences, that the Policyholder/ Insured has experienced in his/her improper performance of tax duties.

18.4. Our rights:

18.4.1. Require and obtain information from the Policyholder necessary to assess the insurance risk.

18.4.2. Handle data of Yours and of the Policyholder in accordance with the procedure laid down by law, including special personal data. In addition to data subjects provided in paragraph 12 of the General part of these Terms and Conditions, You also are the subject of data. We have the right to receive additional information from state registers, banks, and law enforcement authorities necessary to deal with an application to conclude an insurance contract, while determining the insurance payment amounts, when confirming the event as insured, determining the insurance benefit amount and to assess events that took place previously.

18.4.3. Give necessary instructions to You on reducing the damage.

19. Calculation and payment of insurance benefit

19.1. The amount of the damage and insurance benefit is adjusted by us in accordance with the Terms and Conditions specified in the insurance contract and documentation provided to Us.

19.2. The insurance benefit is equal to the amount of loss incurred due to the insured event and, in accordance with the clauses of the Terms and Conditions, to Our indemnified amount of the loss by deducting the deductible specified in the insurance certificate, or in case of variant "Single amount insurance benefit in case of a critical disease", it is the sum insured.

19.3. We shall calculate the insurance benefit on the basis of general (these Terms and Conditions) and individually discussed Terms and Conditions of the insurance contract (provided in the insurance policy and annexes thereof), including but not limited to the insured and non-insured event, price list, if applicable, the part of expenses not paid by the insurer, documents evidencing the insured event and damage incurred due to it but not exceeding the unused part of the sum insured provided in the insurance contract.

19.4. The insurance benefit or the amount of several benefits may not exceed the amount of the risk insurance sum specified in the insurance policy.

19.5. The part of the cost of insurance risk which is not covered by the insurer (i.e. which the insured person has to pay) is in all cases not indemnified.

19.6. The insurance benefit is paid:

19.6.1. To you, when You paid for the services provided at your own expense;

19.6.2. to the institution (Partner), when the services provided are settled under the cooperation agreement with the Partner.

19.7. If the parties disagree on Our estimated amount of the benefit, then conclusions of independent experts shall be followed. If the indemnity is paid by the amount of the damage adjusted in the independent experts' assessment report, or if independent experts are applied for with Our prior consent - in this case, the expenses for independent evaluation shall be borne by Us. In all other cases, these expenses shall be paid by the person who has ordered an independent expertise.

19.8. Insurance benefit shall be paid only after providing Us with the documents confirming the fact of the insured event and documents necessary to determine the size of the insurance benefit. If the insurance benefit is paid to the institution (Partner), the Partner will provide the information and documents required to pay the insurance benefit; however, We have the right, in case of need, to ask You or the Partner to provide additional information or documents, listed in paragraphs 19.9.1-19.10.1, which are needed to be sure of the insured event fact and the size of the damage.

19.9. When applying for a benefit, You must provide us with:

19.9.1. Request to pay the insurance benefit;

19.9.2. Invoice confirming purchase of services and/or acceptance of the goods which specifies the purchaser's or seller's contact information, services and/or goods purchased, and/ or their prices and quantity thereof;

19.9.3. Documents certifying payment for purchased services and/ or products: cash register receipts, cash withdrawal orders, cash-in receipts, bank transfer statements;

19.9.4. Individual activity certificate or business certificate of a person who provided services, if the services have been provided by a person involved in such an activity;

19.10. When applying for the insurance benefit in accordance with risks Outpatient Treatment, Inpatient Treatment, Prenatal care and Childbirth, Dentistry, Medical Rehabilitation, Critical Disease Insurance, Acute Disease and Trauma Insurance, You have to provide Us with the documents specified in paragraph 19.9 and additionally:

19.10.1. Medical records of the institution which has provided personal health care services, wherein a name, surname, date of birth of the patient, date of addressing the personal health care institution, information on health disorder, occurrence of complaints, course of development of health disorders, clearly formed diagnosis and applied treatment shall be indicated.

19.11. When applying for benefits under Medicines and Medical Care, Optics risks You must provide us with the documents referred to in clause 19.9 and in addition:

19.11.1. Purchase recipes (electronic prescriptions) of non-prescription medicines, medical help, optical measures, other goods that are reimbursable by us.

19.12. A request to pay the insurance benefit, which may be submitted in the following ways:

19.12.1. self-service portal gjensidige.lt/savitarna ;

19.12.2. on the website www.gjensidige.lt ;

19.12.3. in the mobile application.

19.13. The insurance benefit shall be paid no later than within 30 days from the date of receipt of all information relevant in determining the fact of the insured event, circumstances, consequences and the amount of the insurance benefit.

20. Cases of reduction and non-payment of the insurance benefit

20.1. We shall be exempt from the payment of insurance benefits, if the Policyholder and/or You do not comply with Our written demands, avoid or refuse to cooperate; do not help or prevent us from clarifying circumstances, confuse Us; provide Us with misleading information or documents; also, perform other actions to obtain undue insurance benefit or a part thereof or obtain a bigger insurance benefit than it is due.

20.2. We are entitled to reduce the insurance benefit if:

20.2.1. The Policyholder or You have failed to perform the Policyholder or your obligations (duties) under Section 18;

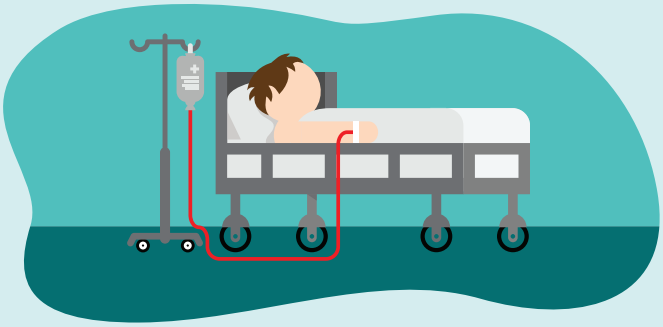
20.2.2. During conclusion of an insurance contract, the Policyholder and/or You provided us with false information which resulted in wrong assessment of insurance risks;
20.2.3. We do not receive documents, specified in paragraphs 19.9-19.11, needed to determine the size of the insurance benefit;
20.2.4. You have obtained a membership (subscription) for health promotion services during the validity period of coverage but a validity period of the membership (subscription) is longer than the validity period of the coverage. In such a case, the insurance benefit shall be proportionally reduced for the coverage period;
20.2.5. You treatment starts prior to the insurance coverage entering legal force or continues following the end of the coverage validity period. In such a case, the insurance benefit shall be proportionally reduced for the coverage period;
20.2.6. You failed to follow a treatment regime or medical recommendations, thus, Your health worsened.
20.3. We are entitled to refuse to pay the insurance benefit if:
20.3.1. When concluding an insurance contract, the Policyholder and You provided Us with false information which would have resulted in our refusal to conclude an insurance contract;
20.3.2. The Goods (services) were not paid for by You;
20.3.3. We do not receive documents, specified in paragraphs 19.9-19.11, needed to determine the event as an insured one.
20.4. Our liability shall end and the insurance benefit shall not be paid if We do not receive a written notice of the event within 30 calendar days after the end of insurance coverage period.
20.5. The insurance benefit shall be reduced by the sum which You have been indemnified by other persons.

21. Insurance coverage validity and expiry

21.1. The coverage shall be valid in the territory of the Republic of Lithuania.
21.2. Your insurance coverage ends earlier than a termination date of the insurance contract:
21.2.1. if You have exhausted the sum insured for all the risks You have coverage for;
21.2.2. After the Policyholder has removed You from the list of insured employees. In case specified in this section We are entitled to submit to the Policyholder information about Your used part of amount of sum insured, without disclosing any detailed information on the use of funds (e.g. names of medical institutions) and/or the purpose of the use of funds (for which services You used the funds);
21.2.3. When You die.
21.2.4. If the coverage is terminated according to paragraph 21.2, We will deduct insurance benefits paid and expected to be paid according to the insurance contract from the returned part of payments for the unused insurance coverage period.

22. Protection of personal data

22.1 The Insurer, when providing health insurance services, shall process personal data of special categories (health) of the Insured on the basis of the consent of the Insured. The processing of such personal data is necessary to enable the Insurer to ascertain the existence of the insured event and to determine the amount of the insurance benefit. In the event that the Insured does not consent to the processing of personal health data, the Insurer shall be entitled not to pay the insurance benefit.
22.2. The Insurer may disclose the Insured person's personal data, including health data, to experts and other persons with special knowledge, when it is necessary to determine the fact of the insured event, the consequences and the amount of the insurance benefit.
22.3. The Insurer shall also receive the Insured person's personal data on the scope, price, time of performance of services provided to the Insured and other relevant data of the Insured in order to pay directly to the institution, which provided services, for the services rendered to the Insured and to protect the Insured person's property interests, related to the insured events, specified in the Policyholder's chosen insurance risks, that are specified in the insurance policy.
22.2.4. More detailed information on how the Insurer handles personal data is provided in the General Terms and Conditions and in the Personal data processing principles published on the Insurer's website www.gjensidige.lt.



Annex no. 1
List of critical diseases

A critical disease is confirmed as an insured event when the disease was diagnosed by a professional doctor of a particular sphere or doctors' Concilium and the Insured has received inpatient treatment as a result of this illness.

1. Myocardial infarction
This is irreversible damage to the part of the heart muscle and death caused by circulatory disorder in coronary arteries. The disease must meet at least three of the following criteria:

- Prolonged chest pain typical to heart attack;
- Recent changes in the electrocardiogram typical to myocardial infarction;
- CK-MB isoenzyme elevations;
- Increase in troponin levels;
- After 3 months after myocardial infarction, left ventricular ejection fraction is less than 50%.

2. Coronary artery bypass graft surgery (CABG)
Open coronary vascular surgery, conducted for the correction of constriction or stoppage of coronary arteries, by using a superficial vein of the leg, internal thoracic or other suitable artery as a transplant. The insurance benefit shall be paid only in such case when the necessity of surgery is reasoned by angiography.
The insurance benefit shall not be paid for:

- Coronary artery balloon angioplasty and all other methods based on catheterization;
- Procedures carried out with laser.

3. Paralytic stroke
Brain cerebrovascular disorder: brain tissue infarction, cerebral hemorrhage and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis, evoking a permanent neurological deficit. Disease must meet all of these criteria:

- The long-term neurologic disorder which is confirmed by the neurologist not earlier than after 6 weeks after the event;
- Magnetic resonance imaging or computed tomography scans show newly emerging changes specific to the paralytic stroke.

The insurance benefit shall not be paid for:

- Transient cerebral circulatory disorders;
- Brain damage due to an accident, infection, vasculitis or inflammatory diseases;
- Vestibular apparatus ischemic disorders.

4. Cancer
A malignant growth which can be characterized by uncontrolled malignant growth of cells and their spread into undamaged organs. The diagnosis must be reasoned by histological tumor malignancy

evidence and approved by doctor oncologist, hematologist or pathologist.
The concept of cancer also embraces leukemia and lymphoma.
The insurance benefit shall not be paid for:

- any tumors when the insured is infected by HIV (human immunodeficiency virus);
- localized non-invasive tumors, having only early malignancy features (carcinoma in situ), premalignant diseases, including, but not limited to: cervical dysplasia CIN-1, CIN-2 and CIN-3;
- Hyperkeratosis, reference cell and squamous cell skin cancer, as well as melanomas, thinner than 1.5 mm according to the Breslow's classification or lower than the 3rd level according to the Clark's classification, except the cases with features of emerging metastases;
- Prostate cancer, histologically defined by TNM classification as being between T1a or analogous prostate cancer according to another classification; T1N0M papillary thyroid microcarcinomas, smaller than a diameter of 1 cm; papillary bladder carcinomas; chronic lymphocytic leukemia, smaller than RAI 3 phases.

5. Renal function failure
A complete renal failure due to chronic and irreversible damage of both kidneys. The insurance benefit shall be paid, if the You need a kidney transplant surgery or regular dialyses are being carried out.
The insurance benefit shall not be paid for:

- Acute renal failure;
- Insufficiency of one kidney functionality or its removal when the other kidney functions normally.

6. Internal organ transplantation
Transplant operation for heart, lungs, kidney, bone marrows, when the You are the recipient. The insurance benefit can also be paid when You are included into the official waiting list for operations (operation has vital indications and there are no contraindications).
The insurance benefit shall not be paid for:

- Organ donors;
- For stem cell transplantation.

7. Coma
A state of unconsciousness lasting at least 96 hours. Disease must meet all of these criteria:

- No response to any external stimuli for at least 96 hours;
- Life support apparatus necessary for life support;
- Brain damage causing a neurological disorder, which should be evaluated at the earliest as 30 days after the onset of coma.

The insurance benefit shall not be paid for:

- Coma directly caused by alcohol or drug abuse.

8. Loss of limb function (Paralysis)/Loss of limbs
Complete and irreversible loss of not less than 2 limbs or loss of their function due to injury or disease.
Loss of limb shall be considered as a loss of limb or its function above the knee or elbow joint for a period not shorter than 6 months.

9. Blindness
Full, constant, irreversible loss of eyesight in both eyes which is not adjustable by medical means or procedures due to trauma or disease. The diagnosis should be clinically based by a physician ophthalmologist. In some cases, blindness may be temporary, in which case the insurance benefit is payable if the total blindness of both eyes persists 6 months after diagnosis.

10. Third degree burns
Third degree (affecting all layers of the skin) burns, which cover at least 20% of the body surface area.

11. Aortic surgery
Open surgery of the thoracic or abdominal aorta during which the affected aortic part is removed and replaced with a prosthesis.
The insurance benefit shall not be paid for:

- Aortic branch surgery;
- Traumatic aortic injury;
- Minimally invasive or intraarterial surgery.

12. Heart valve replacement or function recovery
Replacement of one or more heart valves (aortal, mitral, pulmonary (pulmonary trunk), tricuspid) by prosthesis or functional recovery during open heart surgery due to stenosis, insufficiency or a combination of these factors. Heart valve abnormality must be proved by visual methods (ultrasonography, etc.) or angiographic research methods.
The insurance benefit shall not be paid for:

- The function of heart valve is recovered within the closed surgical intervention.

13. Deafness
Full and irreversible loss of hearing in both ears due to illness or accident. Diagnosis must be proved by audiometric and sound brink research, carried out and approved by the ear, nose and throat specialist (ENT). "Full" means a loss of sound strength of not less than 90 decibels for all frequencies of hearing.

14. Loss of speech
Total loss of ability to speak due to traumatic injury or illness. The benefit is also payable in the event of loss of speech due to surgical and medical treatment of the disease. Diagnosis must be confirmed by a doctor otolaryngologist. In some cases, loss of speech may be temporary, in which case the insurance benefit is payable if the total loss of speech persists 6 months after diagnosis.
The insurance benefit shall not be paid for:

- loss of speech due to mental disorders.

15. Benign brain tumor
A tumor in the brain that meets all of the following criteria:

- Is life-threatening;
- Caused brain damage;
- There was a surgical tumor removal operation or, if it is not operated, it evoked a constant neurological disorder;
- The existence of tumor was confirmed by a doctor neurologist or neurosurgeon. Diagnosis was proved by magnetic resonance imaging, computed tomography scans or other reliable visual research methods.

The insurance benefit shall not be paid for:

- Cysts;
- Granulomas;
- Vascular abnormalities;
- Hematomas;
- Tumors of the pituitary or spine.

16. Fulminant hepatitis
Partial or spread hepatic necrosis, evoked by hepatitis virus, due to which there is a fulminant development of liver failure. Disease must meet all of these criteria:

- Rapid reduction in liver size,
- Entire liver cell necrosis, when there is left only a decomposed cellular system;
- Rapid deterioration of the liver function research;
- Jaundice of increasing severity;
- Hepatic encephalopathy.

The insurance benefit shall not be paid for:

- Liver damage caused by the abuse of alcohol and drugs.

17. Encephalitis
Severe brain inflammation (of brain hemisphere, brain stem or cerebellum), caused by virus infection and whereas there is a constant neurological disorder due to it. Diagnosis must be approved by doctor neurologist, and there should be a constant neurological disorder lasting not less than 6 weeks recorded in the documents.
The insurance benefit shall not be paid for:

- Brain damage caused by the abuse of alcohol and drugs;
- Encephalitis evoked by HIV infection.

18. Bacterial meningitis.
Bacterial infection causing a serious head or spinal cord inflammation, which evokes a significant constant neurological disorder. Disease must meet all of these criteria:

- Bacterial infection found in spinal cord after the conduction of lumbar puncture;
- Neurological disorder, approved by doctor neurologist, lasting at least 6 weeks.

The insurance benefit shall not be paid for:

- Bacterial meningitis when there is a HIV infection.

19. Alzheimer's disease.
Neurodegenerative disease characterized by impairment of cognitive function, behavioral changes, etc.
Disease must meet all of these criteria:

- diagnosis of disease to the Insured is determined while he/she is under 60 years of age;
- Disease confirmed by typical neuropsychological and neural system imaging tests (i.e. computer tomography, magnetic resonance imaging);
- the Insured is diagnosed with a slowly progressive loss of intellectual ability characterized by impairments in memory and cognitive functions (sequence, organizational, generalization, and planning functions) leading to clear impairment of mental and social function;
- Identified personality change and steady decline in cognitive function;
- no consciousness impairment is diagnosed;
- the insured requires uninterrupted care 24 hours a day;
- diagnosis must be made and objectively confirmed by a doctor neurologist.

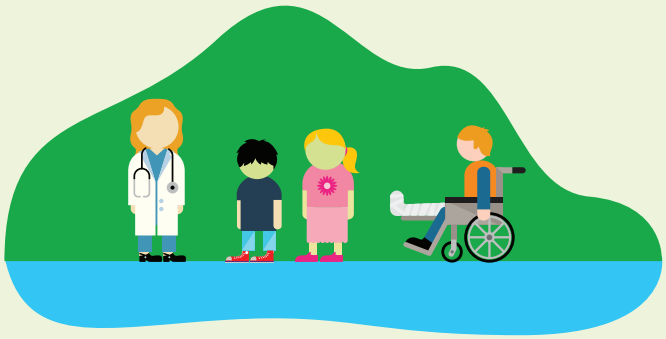
Insurance benefit is not paid in case other forms of dementia (mental illness) due to systemic diseases or diseases related to the brain or psyche of a person.

20. Parkinson's disease.
The initial diagnosis of Parkinson's disease must be made and confirmed by a doctor neurologist.

Disease must meet all of these criteria:

- diagnosis of disease to the Insured is determined while he/she is under 60 years of age;
- at least two of the following clinical signs should be diagnosed:
  - muscle stiffness (rigidity);
  - tremor (shakiness);
  - bradykinesia (pathologically retarded movement, sluggish physical and mental response).
- total inability to perform at least 3 of the 6 daily activities listed below for a continuous period of at least 3 months:
  - "washing" - means the ability to wash or take a bath or shower (including going in and back to a shower or bath) or satisfactory means of washing with other measures;
  - dressing and undressing means the ability to dress, undress, fasten and unfasten any garment, including braces, artificial limbs or other orthopedic appliances as appropriate;
  - eating - the ability to cook on your own when the food is prepared and served;
  - Personal hygiene compliance means the ability to maintain adequate personal hygiene when using the toilet or other means of defecation and urination;
  - room movement - ability to move from room to room on the same floor;
  - getting in and out of bed - The ability to get up/get out of bed to a chair or wheelchair.

In case of implanted brain neurostimulators for the correction of disease symptoms, irrespective of changes in daily abilities, the disease is considered Critical disease.
The need for implantation of a neurostimulator should be confirmed by a doctor neurologist or neurosurgeon.
The insurance benefit shall not be paid for:
- secondary Parkinsonism (including drug or toxin-induced Parkinsonism);
- tremor/Parkinsonism caused by other diseases or causes;
- essential tremor.



II. General insurance conditions

APPROVED:
ADB "Gjensidige" during the meeting of the Board 29 of April, 2021.
Entered into force on 11 of May, 2021.

1. Definitions

1.1. **Policyholder** - the person who has approached the insurer for the conclusion of an insurance contract or to whom the insurer has proposed to conclude an insurance contract, or who has concluded an insurance contract with the insurer.
1.2. **Insurer** - ADB Gjensidige.
1.3. The lists of distributors of ADB Gjensidige insurance products are published at www.gjensidige.lt and www.lb.lt.
1.4. **Insured event** - an event defined in the insurance contract, upon the occurrence of which the insurer must pay the insurance indemnity.
1.5. **Insurance cover** - the insurer's obligation to pay an insurance indemnity upon the occurrence of an insured event.
1.6. **Insurance premium** - the amount of money specified in the insurance contract, which the policyholder shall pay to the insurer for the insurance cover in accordance with the procedure determined in the insurance contract.
1.7. **Insurance indemnity** - the amount of money that the insurer must pay the policyholder or another person entitled to the insurance indemnity upon occurrence of an insured event, or another indemnity form specified in the insurance contract.
1.8. **Insurance period** - the time period from the beginning to the end of the insurance cover, which does not necessarily coincide with the period of the insurance contract. Unless specified otherwise in the terms and conditions of the insurance contract, the insurance cover is considered to be valid only during the insurance period.
1.9. **The period of the insurance contract** - the period of validity of the insurance contract specified in the insurance policy, applicable under the proper and timely performance of the contractual obligations by the parties.
1.10. **Insurance policy** - the document issued by the insurer confirming the conclusion of the insurance contract.
1.11. **Insurance risk** - the probable danger to the object of insurance.
1.12. **Sum insured** - the amount of money specified in the insurance contract or calculated in accordance with the procedure determined in the insurance contract, which the insurance indemnity cannot exceed, except for the cases specified in the insurance contract.
1.13. **Insurance contract** - the written agreement between the insurer and the policyholder concluded on the basis of the terms and conditions of insurance type. In keeping with the contract, the policyholder shall undertake to pay the insurance premium specified therein. In keeping with the contract, the insurer shall undertake to pay an insurance indemnity upon the occurrence of an insured event. The insurance contract consists of:

- insurance policy and its appendices;
- insurance terms and conditions and (or) other provisions of insurance contract agreed upon in writing

between the policyholder and the insurer (individual terms and conditions of the insurance contract);
- application for the conclusion of an insurance contract if one was submitted.

1.14. **Insurance terms and conditions** - standard terms and conditions of the insurance contract prepared by the insurer and consisting of:

- general insurance conditions;
- conditions of insurance type;
- additional conditions of insurance type. The insurance contract is subject only to the additional conditions of insurance type specified in the insurance policy.

In case of discrepancies between the general insurance conditions and the conditions of insurance type, the conditions of insurance type shall prevail. In case of discrepancies between the additional conditions of insurance type and the general insurance conditions or the conditions of insurance type, the additional conditions of insurance type shall prevail.
The terms and conditions of the insurance are published on the website of the insurer www.gjensidige.lt. Also, its copy shall be presented to the policyholder upon concluding an insurance contract.
If certain cases are not discussed in these Insurance Terms and Conditions, the laws of the Republic of Lithuania shall apply.

1.15. **Insurance value** - the value of the insured property or property risk value.

1.16. **Deductible** - a fixed amount of money or an amount expressed in percentage or otherwise specified in the insurance contract, by which the insurance indemnity to be paid upon occurrence of an insured event is reduced (the policyholder shall contribute this amount to the compensation of losses himself).

1.17. **Unconditional deductible** - an amount of money by which the insurer reduces the indemnity to be paid upon occurrence of any insured event. Unless specified otherwise in the insurance contract, the deductible shall be deemed to be unconditional.

1.18. **Conditional deductible** - the share of the loss expressed in the amount of money that the policyholder shall cover in case the loss incurred does not exceed the amount of deductible. In case the loss exceeds the amount of deductible, the indemnity shall be paid without deducting the deductible.

1.19. **Beneficiary** - the person specified in the insurance contract or the person assigned by the policyholder or, in certain cases specified in the insurance contract, by the insured entitled to receive insurance indemnity.

1.20. **Non-insured event** - an event defined in the insurance contract or by law upon occurrence of which the insurer shall not pay the insurance indemnity.

2. Concluding the insurance contract

2.1. The insurance contract is concluded upon agreement between the insurer and the policyholder.

2.2. If the terms and conditions of insurance type do not specify otherwise, the policyholder is entitled to conclude the insurance contract in regard to the financial interests of himself or of another person specified in the insurance policy. Such person becomes the insured. The terms and conditions of the insurance contract that apply to the policyholder also apply to the insured except for the obligation to pay insurance premium.

2.3. The policyholder shall submit to the insurer a written application for the conclusion of an insurance contract or shall otherwise express his will to conclude it (on internet, by phone, by e-mail, in customer service office).

2.4. The policyholder is responsible for the accuracy of the data provided in the application for the conclusion of the insurance contract.

2.5. The conclusion of the insurance contract is confirmed by the insurance policy issued by the insurer. Until the insurance premium or the first instalment of it is paid, the insurance policy shall be considered as insurance proposal, unless the insurance contract provides for the deferment period of the insurance premium or the first instalment of it.

2.6. The Insurer processes data of the object of insurance when assessing insurance risk. Depending on the object of insurance such data may be obtained from entities such as the Real Property Register of the State Enterprise Centre of Registers, State Enterprise Regitra or the Motor Insurers' Bureau of the Republic of Lithuania. More information is provided in the Principles of Personal Data Processing that can be found on the website of the insurer www.gjensidige.lt.

2.7. A different procedure for conclusion of the insurance contract may be defined by the conditions of insurance type.

3. Validity and amendment of the insurance contract

3.1. The insurance contract is made for the period agreed upon by the parties and specified in the insurance policy.

3.2. The insurance contract comes into effect from 00:00 (Lithuania time) of the day specified in the insurance policy, unless a different time is specified in the insurance contract, but not before the full insurance premium or the first instalment thereof is paid, unless the insurance contract provides for the deferment period of the insurance premium or the first instalment thereof:

3.2.1. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is paid prior to the commencement of the insurance contract specified in the insurance contract, the insurance contract comes into effect and the insurance cover applies from the commencement of the insurance contract specified in the insurance contract;

3.2.2. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is not paid prior to the commencement of the insurance contract specified in the insurance contract but the payment is delayed less than 30 calendar days, the insurance contract comes into effect but the insurance cover applies from 00:00 of the day following the day of the payment; the period of the insurance contract shall not be prolonged in such case;

3.2.3. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is not paid prior to the commencement of the insurance contract specified in the insurance contract and the payment is delayed 30 calendar days or more, the insurance contract does not come into effect, and the insurance cover does not apply, and the late payment of the insurance premium shall be returned to the policyholder;

3.2.4. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is paid only partially, the insurance contract does not come into effect and the insurer shall not provide the insurance cover, unless specified otherwise in the written insurance contract.

3.2.5. If the insurance contract provides for the deferment period of the insurance premium or the first instalment thereof, the commencement of the insurance contract is not linked to the payment of the premium and the insurance contract comes into effect and the insurance cover applies from the commencement of the insurance contract specified in the insurance contract. If the policyholder fails to pay the deferred insurance premium (or the first instalment thereof in case the premium is paid in instalments) within the time specified in the contract, standard consequences of non-payment of the insurance premium shall apply as specified in clauses 4.6-4.7 of these General Insurance Conditions.

3.3. If the insurance contract is concluded by means of communication (clause 7.3.2 of these General Insurance Conditions), the commencement of the contract is set at 14 days from the conclusion except for the cases when the policyholder indicates an earlier date. If the policyholder

indicates an earlier date for the commencement of the contract, the insurance cover shall be deemed to apply from the date indicated by the policyholder (before the cancellation term applicable to the contracts made by means of communication expires) but not before the full agreed insurance premium or the first instalment thereof is paid.

3.4. The insurance contract may be amended only by a written agreement between the insurer and the policyholder, except for the cases specified therein.

4. Insurance premium and its payment procedure

4.1. The amount of the insurance premium is calculated by the insurer, taking into consideration the information provided by the policyholder, the object of insurance, the sum insured, the insurance risk, other conditions specified in the insurance contract and other relevant information.

4.2. Insurance premiums may be paid by bank transfer, in cash, using electronic banking or the network of insurer's partners. It is possible to pay insurance premiums in cash or by payment card only in some branches indicated by the insurer. The policyholder is responsible for ensuring that the insurance premium he pays reaches the bank account of the insurer on time and that all details identifying the payer and the insurance contract are provided in the payment documents as requested by the insurer.

4.3. The actual date of payment of the insurance premium is the day when the insurance premium is credited to the bank account specified by the insurer or the insurance intermediary authorized by the insurer or paid in cash and meets the requirements of clause 4.2 of these General Insurance Conditions; otherwise it is the day when the insurer identifies the received insurance premium.

4.4. Other persons may pay insurance premiums for the policyholder without acquiring any rights to the insurance contract and the insurance premiums paid.

If the policyholder terminates the insurance contract prior to its termination date or a refundable balance of the insurance premium appears on other basis, it shall be refunded to the policyholder in spite of who has paid the insurance premium or the instalment thereof, except for the special cases specified in the insurance contract or separately agreed upon by the policyholder and the insurer in written.

4.5. If the insurance premium or the instalment thereof is not paid on time, the insurer is entitled to charge interest at the rate of 0.02% of the unpaid amount for every day delayed.

4.6. If the policyholder does not pay the insurance premium or the instalment thereof within the time specified in the insurance contract (except for the cases when commencement of the insurance contract is linked to the payment of the insurance premium or the instalment thereof), the insurer must inform the policyholder about this in written notifying that the insurance contract will be terminated if the policyholder does not pay the insurance premium or the instalment thereof within 30 days from the day when the notification was sent to the policyholder. The procedure for providing information is specified in clause 13 of these General Insurance Conditions.

4.7. In case the insurance premium was paid partially and a refundable balance appears when the contract is terminated due to the failure of payment of the premium, the amounts of money specified in clause 8.3 of these General Insurance Conditions shall be deducted from the refundable balance.

5. Rights and responsibilities of the policyholder and the insurer

5.1. **Rights of the policyholder:**

5.1.1. to get acquainted with the insurance terms and conditions and receive the copy thereof;

5.1.2. in the event of an insured event, to demand that the insurer pay the insurance indemnity in accordance with the procedure established by law and (or) the insurance contract;

5.1.3. to receive information about the investigation of the insured event;

5.1.4. to terminate the insurance contract in accordance with the procedure specified therein;

5.1.5. to demand the amendment of the terms and conditions of the insurance contract or reduction of the insurance premium if the insurance risk decreases, and, if the insurer refuses to amend the terms and conditions of the insurance contract or to reduce the insurance premium, to go to court for the termination or amendment of the insurance contract due to fundamental changes in the circumstances or to terminate the insurance contract in accordance with the procedure specified therein.

5.2. **Responsibilities of the policyholder:**

5.2.1. to submit the written application for the conclusion of an insurance contract and to provide other documents specified therein before concluding the insurance contract. The written application for the conclusion of an insurance contract must be submitted if it is required by the conditions of insurance type.

5.2.2. to provide the insurer with all the information known about circumstances that might have fundamental impact on the probability of occurrence of an insured event or on the extent of probable loss in case of such event (on the insurance risk). Fundamental circumstances about which the policyholder must inform the insurer before concluding the insurance contract:

5.2.2.1. the information provided in the written application for the conclusion of an insurance contract (if such application is required by the terms and conditions of insurance type);

5.2.2.2. the information requested by the insurer in written;

5.2.2.3. the information requested by the insurer when the insurance contract is concluded on internet or by phone;

5.2.2.4. the information about other insurance contracts under which the object of insurance is insured against the same risks;

5.2.2.5. in addition to the circumstances mentioned above, the conditions of insurance type might define other circumstances that might have fundamental impact on risk assessment;

5.2.3. to inform the insured, the beneficiary and (or) the payer about the insurance contract to be concluded and (or) the insurance contract concluded; to acquaint the insured and (or) the beneficiary with the terms and conditions of the insurance contract and their amendments; to ensure that the insured and (or) the beneficiaries do not object to their appointment as the insured and (or) beneficiary throughout the period of the insurance contract. to inform the insured, the beneficiary and (or) the payer that their personal data has been provided to the insurer for the purpose of concluding the insurance contract, and to acquaint them with the ADB Gjensidige policies of processing personal data;

5.2.4. to pay insurance premiums within the terms specified in the insurance contract; when making the payment, to provide in the payment documents all details identifying the payer and the insurance contract as requested by the insurer;

5.2.5. to follow the insurer's instructions in order to reduce the risk and to comply with the security measures specified in the conditions of insurance type, additional conditions or in the insurance contract; also, to follow the insurer's instructions given throughout the period of the insurance contract;

5.2.6. to inform the insurer immediately about the increase in risk or other cases when the circumstances specified in the insurance contract changes fundamentally; the increase in risk and other cases that fundamentally change the circumstances specified in the insurance contract are defined in the conditions of insurance type, additional conditions or in the insurance contract;

5.2.7. upon the occurrence of an insured event or upon the occurrence of circumstances that cause actual risk of the occurrence of an insured event, to register the event on the insurer's website www.gjensidige.lt, on self-service or by phone (1626) and to exercise the responsibilities specified

in the conditions of insurance type, additional conditions or in the insurance contract; also, to follow the instructions given by the insurer upon the registration of the event.

5.3. **Rights of the insurer:**

5.3.1. before concluding the insurance contract, the insurer is entitled (but is not obliged) to inspect or to assess the object of insurance and, if necessary, to appoint experts to assess the insurance risk at its own expense. Assessments performed by the insurer, any written report thereof, opinion expressed orally or in written shall be considered only insurance risk assessment and may not be used by the policyholder as the proof that the object of insurance is safe, does not cause danger to the environment, complies with the laws and regulations, engineering, industry standards or other requirements;

5.3.2. if the interest of the insurance is linked to the health of a natural person, the insurer is entitled to require the policyholder to provide documents confirming the age, health status, profession of the policyholder (the insured) and other circumstances affecting the insurance risk;

5.3.3. to refuse to conclude the insurance contract without indicating the reason;

5.3.4. to demand the amendment of the terms and conditions of the insurance contract or recalculation of the insurance premium if the insurance risk increases or other fundamental circumstances of the insurance contract changes; and, if the policyholder refuses to amend the terms and conditions of the insurance contract or to pay an increased insurance premium, to go to court for the termination or amendment of the insurance contract due to fundamental changes in the circumstances of the contract;

5.3.5. in case the policyholder fails to inform the insurer about the increase in insurance risk or about the fundamental changes in the circumstances of the insurance contract, the insurer is entitled to demand termination of the contract and compensation of losses to the extent that exceeds the premiums received; the cases of the increase in insurance risk are defined in the conditions of insurance type, additional conditions and other documents constituting insurance contract.

5.3.6. to terminate the insurance contract in accordance with the procedure established by law and terms and conditions of insurance;

5.3.7. to apply fee for issuing a duplicate of the insurance policy.

5.4. **Responsibilities of the insurer:**

5.4.1. to pay insurance indemnity only after assuring that the insured event has actually occurred;

5.4.2. to amend conditions of the insurance contract and to recalculate insurance premium if the insurance risk decreases due to fundamental changes in circumstances during the period of the contract;

5.4.3. if the insurance contract is terminated, to refund the insurance premium paid for the remaining period of the insurance contract, except for the cases specified in the terms and conditions of insurance when unused part of the premium is not refunded.

5.5. Additional rights and responsibilities of the parties may be specified in the conditions of insurance type, additional conditions and in the insurance contract.

6. The procedure of paying insurance indemnity

6.1. Insurance indemnities for insured events shall be paid within the limits of insurance cover as agreed upon in the conditions of insurance type.

6.2. The insurance cover shall apply for all insured events occurred within the period of insurance contract. If the insurance contract provides for the application of insurance cover to the insured events that have occurred before the insurance contract has come into effect, such condition shall apply if the parties of the insurance contract were not aware, were not obliged to be aware and could not be aware of the insured event that occurred before the insurance contract came into effect.

6.3. The policyholder, the insured and (or) the injured third party must provide the insurer with all the documents and information on the causes and consequences of the event that may be recognized as insured event necessary to assess the amount of insurance indemnity, as well as all the documents and information confirming certainty of the insured event, persons liable and extent of damage.

6.4. The terms of paying insurance indemnity:

6.4.1. insurance indemnity shall be paid within 30 days from the day when the insurer receives all the documented information relevant and essential to assess the fact of the event, its circumstances, consequences and to calculate the amount of insurance indemnity;

6.4.2. if, as a result of the event that may be recognized as insured event, the policyholder, the insured or the beneficiary is sued in civil action, criminal proceedings are instituted, legal proceedings are initiated against him or her, a pre-trial or other mandatory investigation by a state institution is carried out, the insurer is entitled to defer the payment of insurance indemnity until the end of pre-trial investigation or until the end of other mandatory investigation by a state institution and (or) until the court decision comes into effect or until the suspension or termination of the case;

6.4.3. if the insurance indemnity is not paid, the insurer shall inform the policyholder (the beneficiary or the injured third party) in written about the progress of the investigation of the insured event every 30 days from the day when the notification about the insured event was received, except for the cases when documents or information are missing only from the policyholder (the beneficiary or the injured third party) and the policyholder (the beneficiary or the injured third party) is already informed about the documents or information that must be provided for the investigation of the insured event;

6.4.4. if the event is recognized as insured event, but the policyholder and the insurer do not agree on the amount of the insurance indemnity, and the assessment of the exact extent of damage continues for more than 3 months, upon the request of the policyholder, the insurer must pay the amount equal to the undisputed insurance indemnity.

6.5. The insurance indemnity shall be paid by bank transfer to the current account.

6.6. If the insured is a minor, the insurance indemnity shall be paid:

6.6.1. to his personal bank account, if the minor has it and its number is provided to the insurer;

6.6.2. if the minor is under fourteen years old and does not have a personal bank account, insurance indemnity shall be paid to the bank account of one of his parents or guardians upon receival of a request of one of the parents or guardians and written agreement of the other parent or guardian;

6.6.3. if the minor is between fourteen and eighteen years old and does not have a personal bank account, insurance indemnity shall be paid to the bank account of one of his parents or guardians upon receival of the written agreement of the minor.

6.7. When paying the insurance indemnity to the policyholders who are entitled to claim for a tax refund in accordance with the procedure determined by law in order to restore the object of insurance to the previous condition, the insurer shall reduce the insurance indemnity by the amount corresponding to the possible tax refund. In such case, when calculating insurance indemnity, the amount of tax is deducted first and then the deductible.

6.8. The exemption from paying insurance indemnity:

6.8.1. the insurer shall be exempt from paying the insurance indemnity if the insured event occurred due to the intention of the policyholder, the insured or the beneficiary, except for the cases specified by legal acts;

6.8.2. the insurance indemnity shall not be paid if the claim for payment is based on fraud, i.e. if the policyholder, the persons related to him, the insured or the beneficiary have tried to mislead the insurer by falsifying the facts, providing incorrect data, unlawfully increasing the amount of loss;

6.8.3. legal acts may provide for additional cases for exemption from paying insurance indemnity.

6.9. The insurer is entitled to reduce the insurance indemnity or to refuse to pay it if the policyholder, the insured and the beneficiary, or anyone of them:
6.9.1. do no inform the insurer properly, provide incorrect or incomplete information on the insured event;
6.9.2. do not take measures to prevent occurrence of damage or to reduce its extent;
6.9.3. do not comply with the terms and conditions of the insurance contract or with the reasonable requirements of the insurer related to the reduction of insurance risk;
6.9.4. do not provide the insurer with an opportunity to properly assess the amount and (or) causes of losses;
6.9.5. do not take measures to enable the recovery of compensation for the damage from the person who has caused it, or act in a way that impedes the insurer to exercise the right of this claim (subrogation);
6.10. If, upon occurrence of the insured event, the policyholder fails to provide information on fundamental circumstances due to negligence, the insurer must pay a part of the insurance indemnity that would be paid to the policyholder under proper performance of his obligations in proportion to the ratio between the agreed insurance premium and the insurance premium that would have been calculated knowing the missing information.
6.11. Deduction of insurance premium:
6.11.1. the insurer is entitled (but is not obliged) to deduct from the insurance indemnity an unpaid insurance premium corresponding to any insurance contract concluded if the term of the payment has passed; also, other amounts that have not been paid on time; if no deduction is made, the policyholder remains obliged to pay the determined insurance premiums and other arrears;
6.11.2. if the insurance contract terminates upon the payment of the insurance indemnity, all the unpaid insurance premiums corresponding to this insurance contract shall be deducted from the insurance indemnity.
6.12. If the same object is insured under several insurance contracts with different insurers (double insurance) and the sum insured exceed the insurance value, the insurance indemnity shall be paid in proportion to ratio of the sums insured under all insurance contracts.
6.13. If, after paying the insurance indemnity or part thereof, it turns out that according to the conditions established in the insurance contract the indemnity should not have been paid or should have been lower, upon the written request by the insurer, the policyholder must refund him the insurance indemnity or the amount overpaid within 30 calendar days, except for the cases determined by law. The same obligation applies to the insured or the beneficiary.
6.14. The insurer shall not provide insurance cover and shall not pay insurance indemnity if the provision of insurance cover and payment of insurance indemnity is subject to United Nations, European Union or other international trade, economic or other sanctions, prohibitions, restrictions and other laws and regulations applicable to the insurer.

7. Termination of the insurance contract

7.1. The period of the insurance contract terminates at 24:00 (Lithuania time) of the day indicated in the insurance contract (policy) unless different time is indicated in the insurance contract (policy).
Towards the expiration of the insurance contract, within reasonable time limit, the insurer is entitled to remind the policyholder about the expiration of the insurance contract and to propose to prolong the insurance cover by sending an insurance proposal of the same insurance type for a new period. The insurance proposal shall specify the sums insured, premiums and other conditions applicable. It should also specify how the policyholder can express his will in regard to accepting the proposal. The policyholder who does not wish to receive the reminder about the expiring insurance contract may submit his refusal to the insurer by phone 1626.

7.2. **The insurance contract shall terminate prior to the expiration date:**
7.2.1. if the probability of the insured event or the insurance risk has disappeared due to reasons unrelated to the insured event;
7.2.2. if the insurer pays all indemnities corresponding to the sum insured for the entire period of insurance contract as determined by the insurance contract;
7.2.3. if the object of insurance is completely destroyed (as specified in the conditions of insurance type);
7.2.4. if the policyholder (legal entity) is liquidated and there is no successor of his rights and responsibilities;
7.2.5. if the owner of the insured property changes, unless the parties of the insurance contract and the new property owner agree otherwise in writing or when the policyholder becomes the new owner himself (e.g. the policyholder redeems the property by leasing or otherwise). On the basis specified in this section the insurance contract is terminated the next working day after the policyholder is informed about the corresponding changes;
7.2.6. if the policyholder does not pay insurance premium or the instalment thereof after the notification from the insurer (clause 4.6 of these General Insurance Conditions);
7.2.7. if there are other grounds for termination of the contract or the obligations determined by law or the insurance contract.
7.3. **Termination or withdrawal of the insurance contract at the initiative of the policyholder:**
7.3.1. the policyholder is entitled to terminate the insurance contract for any reason by notifying the insurer in written at least 15 days prior to the desired date of termination;
7.3.2. the policyholder who is a natural person and has concluded insurance contract for purposes that are not related to business, trade, craft, or profession remotely, only by the means of communication (on internet, by phone, by email), or in another way without physically meeting the insurer is entitled to withdraw from such insurance contract within 14 calendar days after concluding the contract, except for:
7.3.2.1. insurance contracts with the period thereof shorter than one month;
7.3.2.2. insurance contracts that, upon the request of the client, have been exercised completely by both parties (i.e. the insurer has provided the insurance cover and the policyholder has paid the insurance premium) before the end of the 14 days term from the date of the conclusion of the insurance contract;
7.3.3. the policyholder is entitled to terminate the insurance contract in other cases and in accordance with the procedure determined by other legal acts, or by the insurance contract.
7.4. **Termination of the insurance contract at the initiative of the insurer:**
7.4.1. if, after concluding the insurance contract, it turns out that the policyholder or the insured has provided the insurer or his representative with the knowingly false information on fundamental circumstances, the insurer is entitled to declare the insurance contract invalid, unless the circumstances concealed disappeared before the occurrence of the insured event or did not affect it;
7.4.2. if the policyholder or the insured have failed to provide information on fundamental circumstances due to negligence, within two months after the revelation of such circumstances the insurer is entitled to propose to the policyholder to amend the insurance contract. If the policyholder refuses to amend the contract or does not respond to the proposal of the insurer within one month, the insurer is entitled to demand termination of the insurance contract;
7.4.3. if the insurer knowing the circumstances, about which the policyholder failed to inform due to negligence, would not have concluded the insurance contract, the insurer is entitled to terminate the insurance contract within two months from the revelation of the fact that the policyholder has failed to provide necessary information due to negligence;
7.4.4. the terms and conditions of insurance type may provide for additional cases when the insurance contract may be terminated at the initiative of the insurer or may expire.

8. Settlement procedure upon termination of the insurance contract

8.1. If the insurance contract is terminated or expires before the end of its period, the insurer is entitled to the part of the premium for the term of validity of the insurance contract.

8.2. If the insurance contract expires or is terminated in accordance with clauses 7.3.2-7.3.3, 7.5.1 of these General Insurance Conditions, the remained part of insurance premium is not refunded to the policyholder.

8.3. If the insurance contract expires or is terminated at the initiative of the policyholder or in accordance with clauses 7.3.4-7.3.7, 5.1.2 or 8.4.2 of these General Insurance Conditions, the insurer shall deduct from the refundable part of the premium the expenses of conclusion and exercise of the contract (20% of the premium for the unused part of insurance period no longer than one year but not less than 14 EUR); if it is impossible to deduct the expenses of conclusion and exercise of the contract from the part of the premium paid by the policyholder (the amount paid is insufficient), such expenses shall be covered by the policyholder. The fees to be paid or refunded are revised not sooner that the next day after the insurer is informed about the circumstances that form the basis for termination or expiration of the insurance contract.

8.4. In case the policyholder withdraws from the insurance contract concluded by means of communication (clause 7.3.2 of these General Insurance Conditions) within 14 days from the conclusion of the insurance contract:

8.4.1. if the insurance cover has not been provided, the full paid insurance premium shall be refunded without deducting administrative costs;

8.4.2. if the insurance cover has been provided, the unused premium is refunded after deducting the part of the premium that corresponds to the period when the insurance cover was valid.

8.5. If the policyholder had not paid all the insurance premiums agreed before the termination or expiration of the insurance contract, upon the termination or expiration of the insurance contract he must pay the part of insurance premium corresponding to the insurance cover provided until the termination or expiration of the insurance contract.

8.6. The refundable insurance premium or the part thereof shall be transferred to the current account indicated by the policyholder within 14 working days from the receival of written request by the policyholder but not before the termination or expiration of the insurance contract.

9. Terms and conditions for the insurance contract longer than one year

9.1. If the period of the insurance contract is longer than one year, at the end of each current insurance year, the insurer is entitled to:

9.1.1. determine different sums insured, insurance premiums and deductible for the next year (e.g. in order to avoid incomplete insurance, due to inflation, amendments of law or reinsurance conditions, loss history, etc.);

9.1.2. apply new edition of insurance terms and conditions for the next year.

9.2. The new terms and conditions of the insurance contract shall come into effect from the beginning of the next insurance year only if both of the following conditions are met:

9.2.1. the insurer has submitted to the policyholder (and, if applicable, to the beneficiary) the written proposal for the amendment of the terms and conditions of the insurance not later than 1 month before the end of the current insurance year, and

9.2.2. the policyholder and (or) the beneficiary have not notified the insurer in written about the disagreement to the amendment of the terms and conditions of the insurance before the end of the current insurance year.

9.3. If the policyholder and (or) the beneficiary disagree with the amendments of the terms and conditions of the insurance proposed by the insurer and notify the insurer about this in written before the end of the current insurance year, the insurance contract shall terminate at the end of the current insurance year and all the insurance premium paid for the remaining period of the insurance contract shall be refunded to the policyholder without deducting the expenses of the conclusion and exercise of the insurance contract.

9.4. If the insurer does not submit the proposal to amend the terms and conditions of the insurance, the insurance contract remains valid for the next year under the same terms and conditions and the same premium must be paid at the same terms as the previous year.

10. The responsibility of data protection

10.1. The insurer shall protect the information received about the policyholder, the insured or the beneficiary and shall not disclose it to third persons, except for the cases specified by legal acts.

10.2. Information about the policyholder, the insured and the beneficiary may be revealed:

10.2.1. to courts, law enforcement, supervisory, dispute resolution and other institutions in cases specified by law;

10.2.2. to reinsurers and to the companies of the insurer's shareholder group;

10.2.3. to the experts, representatives, consultants and other entities hired by the insurer and providing services to the insurer;

10.2.4. upon receival of a written request or approval by the policyholder, to the insured or the beneficiary;

10.2.5. in other cases specified by legal acts.

11. Transfer of rights and responsibilities determined by the insurance contract

11.1. The insurer is entitled to transfer the rights and responsibilities arising from the insurance contract to other insurers in accordance with the procedure determined by law. The insurer must notify about the intention to transfer the rights and responsibilities arising from the insurance contract in accordance with the procedure determined by law.

11.2. The policyholder is not entitled to transfer his rights and responsibilities arising from the insurance contract without written approval of the insurer.

12. Procedure for resolving disputes between the policyholder and the insurer

12.1. Complaints regarding the activities of the insurer or the distributor of insurance products can be submitted to ADB Gjensidige by e-mail info@gjensidige.lt or by post to the insurer's registered office address Žalgirio 90, Vilnius.

12.2. Detailed information on the procedure for submitting complaints and resolving disputes, including complaints regarding the activities of the distributor of insurance products, is published on the insurer's website www.gjensidige.lt.

12.3. Disputes arising from the insurance contract shall be resolved by negotiations. If the parties do not reach an

agreement, the dispute shall be resolved out of court at the Bank of Lithuania, Totorių 4, LT-01103 Vilnius (for more information visit www.lb.lt) or in the competent court of the Republic of Lithuania.

12.4. Insurance contracts are subject to the law of the Republic of Lithuania, unless the parties have agreed otherwise in the insurance contract (individual insurance contract or insurance policy).

13. Procedure for providing information to the other party of the contract

13.1. Any notification that must be submitted by one party of the insurance contract (as well as by the insured and the beneficiary) to the other party must be submitted in written.

13.2. Notifications sent to the other party by ordinary mail, by e-mail or by courier to the addresses specified in the insurance contract or submitted on the insurer's self-service website shall be deemed to be presented properly.

13.3. It shall be considered that the proper day of presenting the notifications is:

13.3.1. the next working day after sending the notification by e-mail;

13.3.2. if the notification is sent by post:

a) the notification sent by ordinary mail shall be considered as submitted after a reasonable time from the day it has been sent;
b) the date of the receival of the notification sent by registered mail is indicated on the official stamp of the post office;
c) the date of the receival of the notification sent by courier is considered to be the day of its delivery to the addressee;

13.3.3. the next working day after submitting the notification on the self-service website of the insurer;

13.4. The parties of the insurance contract must inform each other about the changed address or other contact details within 15 days from the day such data has changed. The policyholder may provide the insurer with the information about the changed contact details by telephone (1626), on the self-service website of the insurer, or by other means specified in clause 13.3 of these General Insurance Conditions.

14. Protection of personal data

14.1. The insurer in performance of the contract acts as a controller of the data and processes personal data in accordance with the General Data Protection Regulation (hereinafter referred to as GDPR), the Law on Legal Protection of Personal Data of the Republic of Lithuania and other legal acts that regulate protection of personal data.

14.2. The insurer shall process personal data only for predefined purposes in order to be able to conclude and exercise insurance contract and to exercise actions related to it: to identify the party of the insurance contract, to acquire information about the property insured, to assess and control insurance risk, to prepare insurance proposal and draw insurance contract, to assess the extent of the damage, to administer insured events, as well as operations of insurance premiums and insurance indemnities (including invoicing and debt recovery), to contact the policyholder in regard to the exercise of the contract or to remind about the ending insurance contract.

14.3. The insurer in compliance with the legal acts applicable is entitled to process personal data not only of the policyholder but also of other parties involved. Depending on the specifics of insurance product and particular situation the insurer shall process personal data of the beneficiaries, the insured, the payers and other persons involved in the exercise of the insurance contract.

14.4. As a controller of the data, the insurer is entitled to use services of data administrators that process personal data on behalf of the insurer.

14.5. The insurer shall process personal data only when: it is necessary for the conclusion of the insurance contract and/or for the exercise of the insurance contract that has already been concluded; the insurer must process personal data as he is obligated so by legal acts; approval to process personal data is granted; personal data has to be processed for legal interests of the insurer or a third party.

14.6. Persons whose personal data is processed by the insurer (hereinafter referred to as the data entities) have following rights: to familiarize with the personal data processed by the insurer; to request to correct their data that is incorrect or inaccurate; to delete personal data that is processed illegally; to request the insurer to restrict the processing of the personal data; to request the insurer to transmit the data processed; to object to the processing of personal data; to cancel direct marketing authorizations at any time; to submit a claim to the supervisory authority.

14.7. The insurer shall review the request of the data entity and give a response within one month from the receival of the request. This period may be prolonged by two more months taking into consideration the complexity and number of requests.

14.8. The Insurer has appointed a data protection officer, whose contact e-mail address is dpo@gjensidige.lt.

14.9. Detailed information on how the insurer processes personal data and on procedure for the exercise of the rights of the data entities is provided in the Principles of Personal Data Processing on Insurer's website www.gjensidige.lt.

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