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Terms and Conditions – Life Insurance NN Smart UZ3C

Key Information Document 2

General insurance conditions for life insurance 4/2018 8

Special insurance conditions of main insurance UZ3C 12/2016 15

SPC CSO3/CSO6 version 5/2017 21

SPC CSO4/CSO5 version 5/2017 23

SPC 0012 version 5/2017 25

SPC 0314 version 5/2017 27

SPC CTN2 version 5/2017 35

SPC CID6/CID7 version 5/2017 43

SPC CIDA/CIDB version 5/2017 46

SPC CID8 version 5/2017 49

SPC CIDC version 5/2017 52

SPC CUD3 version 5/2017..... 55

SPC COP2 version 5/2017 58

SPC CDI2 version 5/2017 61

SPC CZR1/CZR3 and CZV1/CZV3 version 5/2017 63

SPC CZR5/CZV5 version 5/2017 76

SPC CZV2 version 5/2017 79

SPC 0026 version 5/2017 88

SPC CDL1 and CDL2 version 5/2017 91

SPC CDU1 and CDU2 version 5/2017 94

SPC CHO1/CHO4 and CHO2 version 5/2017 96

SPC CHU1/CHU4 and CHUF version 5/2017 99

SPC CDN2 version 5/2017 102

SPC CPN5/CPN6 version 5/2017 106

SPC CAS4 version 5/2017 110

Identification Completion 113

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KEY INFORMATION DOCUMENT

Purpose

This document provides you with key information about this product. It is not marketing material. The information is required by law to help you understand the nature, risks, costs, potential gains and losses connected with these funds and products, to which they are offered and to help you compare them with other products.

PRODUCT NN SMART

Name of product: Investiční životní pojištění NN Smart

Name of manufacturer: NN Životní pojišťovna, N.V., branch office for the Czech Republic, ID No.: 40763587, seated at Praha 5 - Smíchov, Nádražní 344/25, Postal Code: 15000, Czech Republic, entered into the Trade register maintained by the City court in Prague, Ref. No. A 6305, as an organisational unit of the company NN Životní pojišťovna N.V. seated at Weena 505, 3013Al Rotterdam, Kingdom of the Netherlands, entered into the Trade register of the Chamber of Commerce in Rotterdam, Kingdom of the Netherlands, date of entry January 17, 1863, entry No. 24042211 (hereinafter only the "Insurance company" or "NN"), www.nn.cz, email: klient@nn.cz, Tel: +420 800 127 127.

The supervisory body is the Czech National Bank seated at: Na Příkopě 28, 115 03 Praha 1, Czech Republic. NN Životní pojišťovna performs activity on the territory of the Czech Republic on the basis of the right of an insurance company from another member state to establish its branch office here and this in the scope, in which it was granted to it in the Kingdom of the Netherlands. Due to this reason it is also subject to supervision by De Nederlansche Bank, Westeinde 1, P.O.BOX 98, 1000 AB, Amsterdam, The Netherlands.

The main subject of the insurance company's business is insurance activity according to § 3, paragraph 1, letter f) in connection with § 137, paragraphs 1 and 2 of Act No. 277/2009 Coll., on Insurance (hereinafter only the "Act on Insurance") in the scope of insurance branches I. a), b) and c), II., III. of life insurance mentioned in Part A of the Amendment to the Act on Insurance.

Activities connected with insurance activity according to § 3, paragraph 1, letter n) in connection with § 137, paragraph 1 of the Act on Insurance.

The report on solvency and financial situation of NN Životní pojišťovna is available at the websites www.nnpojistovna.cz and in relation to the parent company at the websites www.nn.nl.

This Key Information Document was issued on 15. 4. 2018.

What is this product?

Type

Unit Linked Insurance

Objectives

This product includes insurance for case of death and achieving the arranged end of insurance by the insured person whereas paid premium decreased by initial costs of the insurance company is used for purchase of units in the financial funds selected by you. The units are registered at the individual units' account maintained to the insurance contract by NN. Subsequently NN costs for coverage of insurance risks and costs connected with rise and administration of the insurance are deducted from the value of the units' account. Financial funds are internal funds of NN representing the portfolio of underlying investments, especially into bonds and monetary market instruments, the Bond Fund, the Mixed Funds or the Equity Funds. Return on investment depends on development of the underlying investments' value. More detailed information regarding objectives of the financial funds, means of their achievements, description of relevant underlying instruments and markets, into which it is invested, as well as the way of their return determination can be found in the Key Information Document to the financial funds. The offer of funds and their underlying assets may change. Determination of funds, into which it should be invested, may change and invested financial means can be transferred among the funds or it is possible to perform a partial or complete withdrawal from the units' account. A fee may be charged for these operations or they can be limited in accordance with the insurance conditions.

Intended retail investor

Determination, for which type of investors is this product appropriate, depends on specific financial funds, into which we invest through it; more detailed information about suitability for various types of investors can be found in the Key Information Document to the financial funds.

Insurance benefits and costs

The policyholder and the insurance company conclude an insurance contract together, by which the insurance company commits itself to provide benefit payment to the policyholder or to a third party if an insured event occurs and the policyholder obliges himself to pay premium to the insurance company. The basis of this product is insurance for case of death and achieving the arranged end of insurance by insurance of the first insured person (hereinafter only the "Main coverage ").The benefit for case of death at the Main coverage is equal to the arranged sum assured or to the value of the units' account depending on the fact, which value is higher (special conditions are valid if the insured person does not achieve the age of three years). Benefit payment is equal to the value of the units' account at achieving the arranged end of insurance by the insured person.

The value of benefit payment in model scenarios is mentioned in the Section called "What risks do I undergo and what yield could I achieve?" in this document and in Key information notification of individual financial funds.

It is also possible to arrange insurance of the second insured person's death to the Main coverage and additional riders covering various insured events whereas benefit payment is not dependent on market development in these cases and it is derived from the arranged sum assured or consists in waiver of premium payment. The overview of riders that can be arranged to the Main coverage or insurance of the second insured person's death, which insured events are covered by these riders, cases, which insurance coverage does not relate to (exclusions from insurance), information about the right of NN to decrease benefit payment and other important information can be found in the insurance conditions and will be explained to you at arrangement of the insurance contract in case of need.

Regular premium is paid for insurance periods and in the way set by the contract. You can also pay additional premium above the scope of regular premium under conditions according to the insurance contract. This additional premium will be used for investments. The amount of regular premium for the Main coverage and riders as well as the ratio between the premium used for coverage of risks and determined for investment are influenced by your specific requirements and other parameters (e.g. age at entry). The exact amount of premium will be calculated before conclusion of the insurance contract and provided to you for consideration.

Period of product duration

This product is arranged for definite period mentioned in the insurance contract, the minimum period, which the product can be arranged for, is 10 years. Insurance duration of the second insured person or of some riders can be set differently.

The insurance contract lapses especially by: expiry of the arranged insurance period; notice by the policyholder delivered in advance six weeks before the end of the insurance period whereas it is also possible to cancel only individual riders; notice by NN delivered in advance six weeks before the end of the insurance period and this only regarding non-life riders; notice by the policyholder or by NN with the notice period of eight days within two months from conclusion of the contract; payment of surrender under conditions mentioned in the insurance contract; withdrawal (see Section "Advice of withdrawal" below); agreement; denial of benefit payment by NN due to the fact that the insured event was caused by a fact, about which NN learned only after the rise of the insured event and it would not have concluded the insurance contract if it had known this fact or it could not have learned about this fact due to violation of obligations by the policyholder or by the insured person; due to non-payment of premium if risk premium is not paid from the value of the units' account; insured event unless set otherwise in the relevant insurance conditions or in other ways set by the law and/or by the insurance conditions. The product

cannot be automatically terminated.

Advice of withdrawal

You have the right to withdraw from the insurance contract without mentioning the reason within 30 days from its conclusion, the period is kept if the withdrawal is sent before its expiry. If the contract had been concluded by remote means, the period is calculated from the day when we informed you about its conclusion. Further on you have the right to withdraw from the insurance contract if NN or the insurance agent answered your written questions concerning the arranged insurance falsely or incompletely or if NN or the insurance agent did not call your attention to discrepancies between the offered insurance and requirements of the policyholder, which NN must have been aware of and this within two months from the day when you learned about it. Please, send the withdrawal to the address of NN mentioned above or by e-mail to the address klient@nn.cz. It is possible to use the sample template Notification of withdrawal that is available at NN website www.nnpojistovna.cz.

NN may withdraw from the contract within two months from the day when it learns about the fact that the policyholder or the insured person answered the questions at the arrangement of the insurance contract falsely or incompletely and under the condition that NN would not have concluded the insurance contract if the questions were answered truthfully and completely.

The insurance contract is cancelled from the beginning by a withdrawal. NN will return the paid premium, from which it will deduct the benefit that has been already paid from the insurance, without an unnecessary delay, latest within 30 calendar days from the day of withdrawal. In case of withdrawal by NN, also costs connected with rise and administration of the insurance are deducted from the paid premium. In such a case, you have the obligation to return the amount of paid benefit exceeding the amount of paid premium within the same period. If the right of the policyholder to withdrawal is not applied under the conditions mentioned above, the insurance contract remains valid and effective. The possibility to terminate the insurance contract in another way as mentioned above is not affected by this.

What are the risks and what could I get in return?

Risk Indicator

The Risk Indicator represents a direction for judgement of this Fund's riskiness in relation to other products. It shows how probable it is that the Fund will bring losses to you due to movements on the market or due to the fact that we would not be able to pay the benefit to you.
Determination of risk and of the return on investment depends on the financial funds, into which we invested through this product. The longer the insurance lasts, the bigger share of paid premium falls to investments. These financial funds are available to this product, whose riskiness is also marked in the risk indicator:
Risk class 1: **Guaranteed Fund**
Risk class 2: **Bond Fund, Mixed Fund II**
Risk class 3: **Czech Equity Fund, World Equity Fund II**
Risk class 4: **Growth Fund**
More detailed information about their riskiness can be found in the Key Information Document to individual financial funds. In case that the recommended period of the product's holding set in Key information notification of individual financial funds is not fulfilled, the risk may be significantly higher than mentioned in the summary risk indicator.

Performance scenarios

Investment

Calculated under the assumption of annual investment in the amount of 27 000 CZK		1 year	16 years	30 years
Survival scenarios				
Stress scenario	**What you might get back after costs** Average return each year	13,972 CZK -48,25 %	316,445 CZK -4,04 %	570,704 CZK -2,37 %
Unfavourable scenario	**What you might get back after costs** Average return each year	14,157 CZK -47,57 %	440,874 CZK -0,09 %	1,119,565 CZK 2,01 %
Moderato scenario	**What you might get back after costs** Average return each year	14,783 CZK -45,25 %	505,162 CZK 1,51 %	1,438,118 CZK 3,48 %
Favourable scenario	**What you might get back after costs** Average return each year	15,453 CZK -42,77 %	583,721 CZK 3,18 %	1,883,512 CZK 5,00 %
Death scenario				
	What you might get back after costs Average return each year	14,783 CZK -45,25 %	505,162 CZK 1,51 %	1,438,118 CZK 3,48 %
Accumulated invested amount		27,000 CZK	432,000 CZK	810,000 CZK

This table specifies the return during the next years according to various performance scenarios under the condition that you invest 27 000 CZK in this Fund per year.
Performance scenarios show potential development of your investment. You can compare them with performance scenarios of other products.
Presented scenarios are forecasts of future performance based on evidence from the past and do not represent a precise indicator. The actual return level depends on market performance and the investment's holding period.
Showed data contain all costs of this Financial Fund. They do not take into consideration your personal tax situation that can also influence the level of return.
The values presented here are based on a model example with the sum assured of the Main coverage 10 000 CZK, without arranged riders, client's age at arrangement of the product is 34 years, client's age as of product termination is 65 years and with allocation of investments in the ratio 57 % into the Growth Fund, 15 % into the Bond Fund and 28 % into the Guaranteed Fund with use of moderate performance scenario (hereinafter only the "Model values "). Model values were set on the basis of average contract parameters of existing clients using this product. The actual performance of investment depends on real parameters of the arranged product including allocation of investment to individual financial funds and their real performance. No warrantees relate to return on investment, maximum losses can achieve the summary of the entire invested capital. You do not bear the risk of rise of other financial liabilities or obligations. Past returns do not guarantee the future ones.
More detailed information about performance of the financial funds can be found in the Key Information Document to individual financial funds.

Tax legislation of your home member state may influence the actual level of the paid amount

Especially Act No. 586/1992 Coll., on Income Tax, regulates tax obligations for tax residents in the Czech Republic in connection with the insurance contract. Income from benefit payments for case of achieving the arranged age, surrender and extraordinary withdrawals are subject to withholding tax on the level of 15 %; determination of the tax base depends on individual circumstances. NN collects and passes on the withholding tax on behalf of the client. Benefit payments for case of death, accident and disease are exempted from the tax. The policyholder can decrease his/her tax base from income tax of natural persons by premium paid to the Main coverage of the insurance contract in the given taxation period if he/she is the insured person at the same time, the end of insurance is arranged only after 60 calendar months from conclusion of the contract and at the same time earliest in the calendar year when he/she achieves the age of 60 years and the insurance contract does not enable extraordinary withdrawals. Maximum amount deductible from the tax base is 24,000 CZK and this also in case of the existence of more insurance contracts.
Tax regulations ae subject to frequent changes. A tax advisor will provide you with information about the topical wording of tax regulations.

What happens if NN Životní pojišťovna, N.V. is not able to make the payment?

In case that NN is not able to make benefit payment, you may suffer financial losses. NN liabilities from insurance are not covered by insurance or warranties, however, NN is obliged to keep the capital on the level set by the law. In case of NN insolvency, claims from insurance are superior to claims of other creditors.

What are the costs of investment?

Costs over Time

Reduction in yield (RIY) shows the impact of total costs paid by you on your potential return on investment. Total costs consider one-off, ongoing and incidental costs.
The amounts mentioned herein represent cumulative costs of the Fund itself for three different holding periods. The data assume that you invest 27 000 CZK into this Fund each year. These data are forecasts and can change in the future.
The calculations are based on Model values. Real costs of the investment depend on real parameters of the arranged product including allocation of investment to individual financial funds. More detailed information about costs of the financial funds can be found in the Key Information Document to individual financial funds.

Calculated under the assumption of annual investment in the amount of 27 000 CZK	If you exit the investment after 1 year	If you exit the investment after 16 years	If you exit the investment after 30 years
Total costs	13,752 CZK	189,966 CZK	678,887 CZK
Impact on return (RIY) per year	50,92 %	3,87 %	2,13 %

The person who sold you this product or give you advises about it can charge other costs. If so, this person give you information about this costs and explain you the impact that all costs will have to your investment.

Composition of Costs

The table below shows the annual impact of various types of costs on return on investment that you could gain at the end of the recommended holding period and significance of the different costs categories.

This table shows the impact on return per year			
Calculated under the assumption of total annual premium in the amount of 27 000 CZK			
One-off costs	**Entry costs**	0,75 %	The impact of the costs you pay when entering your investment.
	Exit costs	0,00 %	The impact of the costs of exiting your investment when it matures.
Ongoing costs	**Portfolio transaction costs**	0,15 %	The impact of the costs of us buying and selling underlying investments for the product.
	Other ongoing costs	0,00 %	The impact of the costs that we take each year for managing your investments.
Incidental costs	**Performance fees**	0.00 %	The impact of the performance fee. You do not pay the performance fee.
	Fee for capital appreciation	0,00 %	The impact of fees for capital appreciation. You do not pay the fees for capital appreciation.

This Composition of Costs is based on model values. The actual Composition of Costs depends on the actual parameters of the agreed product, including the distribution of investments in various financial funds, therefore, it can be significantly different than the model case. For more information about the composition of costs of individual financial funds can be found in the key information document of the individual funds.
Additional impact of your premium payments (corresponding to the anticipated value of benefit payments) is 0 % on the same basis. Details about benefit payments such as benefit in case of death are mentioned in the Section called “What is this product? “.

How long should I keep the investment? Is it possible to withdraw the money prematurely?

Recommended / Minimum requested holding period of investment: for the arranged period of the insurance contract duration

The recommended holding period of the investment is based on the fact that a fee is deducted from the premium during the first 60 months of insurance duration for coverage of the insurance company's initial costs. The longer the insurance lasts, the higher share of the paid premium falls on investments.
Investments into various financial funds are made through this product. It is possible to transfer the financial means among these funds. The first transfer in a year is free, a fee is charged for the others. The level of the fee is mentioned in the Overview of charges. The recommended holding period of investment in these funds depends on their objectives, means of their achievement, underlying instruments and markets, into which investments are made. More detailed information is mentioned in the Key Information Document to individual financial funds.

Termination with payment of surrender
You can terminate the insurance with payment of surrender after the first month of the insurance duration. The surrender amount is equal to the value of the units' account after deduction by outstanding fees and premium. Specific conditions for payment and calculation of surrender are mentioned in the insurance conditions. The amount of surrender is not equal to the summary of paid premium. Expected development of the surrender amount in time is mentioned in modelling of the insurance that is handed over at insurance contract conclusion. NN will also communicate the topical level of surrender to you upon request anytime.
Premature termination of the insurance contract is not convenient for you, as a fee for coverage of initial costs of the insurance is charged for the period of the first 60 months.

Partial withdrawal from the units' account value
In case that the contract is not tax preferred, it is possible to ask for withdrawal of a part of the units' account value anytime. NN is entitled to set the minimum and maximum level of withdrawals and to charge the fee mentioned in the Overview of charges for it. NN has the right to decrease the sum assured set in the insurance contract in case of a withdrawal of a value from the units' account, however, by the requested value of the withdrawal at the most. Specific conditions for payment and deduction of a partial withdrawal from the value of the units' account are mentioned in the insurance conditions.

Warning
You have the right to withdraw from the insurance contract without mentioning a reason within 30 days since its conclusion, the period is kept if notification of withdrawal is sent before its expiry. In case of remote conclusion, the period is calculated from the day when we inform you about conclusion of the contract. The value of units in financial funds may vary in terms of time; their sale at inconvenient moment and this also within a transfer of the financial means into other financial funds, may lead to financial losses.

How can I complain?

Filing of complaint to the insurance company
As regards the activity of NN or the agent, you or another authorised person may file a complaint to the Complaints Department and this in writing, to the address of NN, Oddělení stížností, Praha 5 - Smíchov, Nádražní 344/25, PSČ 15000, by e-mail to the address klient@nn.cz, by fax to the telephone number: 257 473 555, by telephone to the hotline: 800 127 127, personally in the seat of the insurance company or through the form at the website of the insurance company www.nnpojistovna.cz/formular/klientska-zona/stiznost. It must be obvious from the complaint who files it and what is its subject. If it be to the contrary or if it is necessary for its settlement, NN will call on you for supplementation within a set period. If the complaint is not supplemented, it will not be possible to settle it. The period for settlement of a complaint is 30 calendar days and starts to run by the first working day after its delivery or supplementation. Complaints are settled without an unnecessary delay.

Filing of complaint to the performance of the insurance company or agent, decisive law, solution of disputes
It is possible to file a complaint regarding the course of actions made by NN at the Czech National Bank, Financial Market Supervision Department, Division of Supervision above insurance companies or Consumer Protection Division, seated at Na Příkopě 28, 115 03 Praha 1, Czech Republic.
The insurance contract is governed by the law of the Czech Republic. Disputes can be solved by a general court having subject-matter and territorial jurisdiction or out of court through a financial arbitrator, www.finarbitr.cz.
You can also use the on-line Platform for solution of consumer disputes https://webgate.ec.europa.eu/odr/ for solution of a dispute resulting from a contract concluded on-line (through website or other electronic means).

Other relevant information

Other important documents

Detailed information to the financial funds offered to this product can be found in the Key Information Document to individual financial funds that are provided to you along with this document.

Your needs will be analysed before arrangement of the insurance contract. A record will be drawn up about this and a calculation with a specific proposal for setting of the Main coverage, selection of financial funds, arranged riders, total level of premium resulting from it and other parameters will be created subsequently. Insurance conditions (General insurance conditions and Special insurance conditions of arranged insurance types) and Overview of charges represent an integral part of the insurance contract. These documents are available on the basis of requirements set by legal regulations.

This document is elaborated according to the status of legal regulation as of 1. 1. 2018.

Overview of charges connected with Unit Linked Insurance NN Smart – wording valid from 15. 4. 2018

CHARGES

1. Management charge for administrative costs — 20 CZK
(charged monthly for the entire period of insurance duration, paid in the form of units' deduction from the unit account's value)
If the value of invested premium in financial funds and in the guaranteed fund is equal or higher than 200,000 CZK, the management charge for administrative costs of the company is — free

2. Collection charge — 10 CZK
(paid in the form of units' deduction from the unit account's value)
If the value of invested premium in financial funds and in the guaranteed fund is equal or higher than 200,000 CZK, the collection charge is — free

3. Charge for coverage of the insurance company's initial costs

a) The charge for coverage of the insurance company's initial costs for the period of the first 3 years from the insurance start. The amount of this charge is set as so-called allocation percentage from the amount of regular premium (at the main coverage of the 1st insured person) for the first insurance period (the arranged insurance period of the 1st insured person is decisive). If regular premium is decreased during the mentioned period of the first 3 years (at the main coverage of the 1st insured person), the fee in the amount according to the first insurance period is charged for the period of one year from such a decrease at the most and afterwards its level is set as so-called allocation percentage from the topical value of regular premium (at the main coverage of the 1st insured person).

b) The charge for coverage of the insurance company's initial costs for the period of the first 3 years from regular premium increase (at the main coverage of the 1st insured person) if such an increase occurs during insurance contract duration. The amount of this charge is set as so-called allocation percentage from the amount, by which regular premium was increased (the remaining insurance period of the 1st insured person is decisive).
(it is calculated on monthly basis and the insurance company is entitled to it only for started months of the insurance duration; it is paid in the form of a deduction from paid premium or in the form of deduction of units from the value of the units' account; in case of insurance transfer into repaid status and/or at lapse of insurance, these outstanding fees that have not been paid for the period until the date of insurance transfer or until the date of the insurance lapse, will be settled by a single payment)

Allocation percentage									
Duration of cover		**Duration of cover**		**Duration of cover**		**Duration of cover**		**Duration of cover**	
1 year	2.0 %	7 years	2.5 %	13 years	8.5 %	19 years	26.0 %	25 years	41.0 %
2 years	2.0 %	8 years	2.5 %	14 years	11.0 %	20 years	30.0 %	26 years and more	45.0 %
3 years	2.0 %	9 years	3.0 %	15 years	14.0 %	21 years	32.0 %		
4 years	2.0 %	10 years	3.0 %	16 years	17.0 %	22 years	34.0 %		
5 years	2.0 %	11 years	4.0 %	17 years	20.0 %	23 years	36.0 %		
6 years	2.0 %	12 years	6.0 %	18 years	23.0 %	24 years	38 %		

4. Charge for change in basic contract data (personal, regarding payments, etc.) — free

5. Charge for change in technical parameters of insurance (premium, sum assured, rider, etc.) — free

6. Charge for sending a statement from the unit account
- one statement per insurance year — free
- second and further statement per insurance year — 50 CZK
(paid in the form of units' deduction from the unit account's value)

7. Charge for deposit of additional premium — free

8. Charge for change in allocation ratio
- first change in insurance year — free
- second and every other change in insurance year — 50 CZK
(paid in the form of units' deduction from the unit account's value)

9. Charge for transfer of units among individual financial funds
- first transfer in insurance year — free
- second and every other transfer in insurance year — 50 CZK
(paid in the form of units' deduction from the unit account's value)

10. Charge for interruption of obligation to pay regular premium — 150 CZK
(paid in the form of units' deduction from the unit account's value)

11. Charges connected with funds
(not put on policyholder's account but they are already taken into account in the prices of the funds' units)

	From investment's value per year	
	Charge to insurance company for mediation of the fund	**Total cost of the fund**
- Growth Fund	0.90 %	0.81 %
- Bond Fund	0.90 %	0.76 %
- Czech Equity Fund	0.90 %	1.16 %
- World Equity Fund II	0.90 %	0.85 %
- Mixed Fund II	0.90 %	0.78 %

12. Difference between purchase and selling prices – so-called "Bid/Offer spread"
- for regular premium — 3 %
- for additional premium — 0 %

LIMITS

13. Minimum level of additional premium deposit	1000 CZK
14. Extraordinary withdrawals of units	
a) Tax preferred insurance contract: Extraordinary withdrawals of units are not permitted (this is eventually valid also above the scope of arrangements in special insurance conditions to this insurance) with effect from 1.1.2015.	
b) Insurance contract without tax preference Minimum level of extraordinary withdrawal of units	3000 CZK
15. Guaranteed fund	
It guarantees non-negative development of the unit's price and possible appreciation on the level mentioned in the notification at the website www.nn.cz.	
16. Minimum value for insurance transfer into repaid status	3000 CZK

The vocabulary of terms at the end of this document will help you to understand basic expressions used in these general insurance conditions (GTC).

Article 1 - Which legal documents are important for me and how to use them?

1. These GTC are valid for the main life insurance (main coverage) and possible additional insurance (riders) of an accident or a disease arranged by contract parties of the insurance contract. GTC are complemented by the relevant special insurance conditions for the arranged kind of the main coverage and relevant special insurance conditions for arranged riders.
2. GTC as well as special insurance conditions create an integral part of the insurance contract. Provisions of special insurance conditions are superior to these GTC, then specific provisions in the insurance contract are superior to provisions of special insurance conditions
3. Riders may be arranged only as additional insurance to the main coverage.

Article 2 - What is subject of arranged insurance and which events are covered by it?

1. The insurance company obliges itself by the insurance contract to provide benefit payment to the beneficiary if an insured event occurs. The policyholder obliges himself/herself to pay premium to the insurance company.
2. Life insurance is always arranged as the Main coverage in the insurance contract. Optional riders may be arranged to it whereas the riders for case of death, disability, cancer, severe diseases, waiver of premium payment as a result of a disease or accident and long term care rider due to a disease or accident are considered as life insurance in the sense of § 2833 Act No. 89/2012 Coll., the Civil Code.
3. **The insurance company is not obliged to pay the benefit for claims that occurred from the arranged start of insurance until the day when the first regular premium or single premium has been credited in favour of the insurance company's account. If this premium was paid, the insurance company is further not obliged to pay the benefit for claims, which occurred during the period from the arranged start of insurance until issuance of the policy, however, within two months from the insurance contract conclusion at the longest and this with the exception of an insured event caused by an accident that happened at the time of the insurance duration after payment of the first regular or single premium.**

Article 3 - What is necessary to know about insurance contract, start of insurance and changes in insurance?

1. An insurance contract must be concluded in writing. The insurance contract is concluded by the moment of its signature by the insurance company and by the policyholder. It is also possible to arrange an insurance contract remotely in cases set by the insurance company and this especially through websites of the insurance company and through the self service portal of the insurance company.
2. If the proposal for the insurance contract submitted by the insurance company permits it, it can be accepted also by premium payment on the level arranged in the proposal if it happens within the period mentioned in the proposal. In such a case the insurance contract is concluded as soon as premium has been credited in favour of the insurance company's account.
3. The insurance company will confirm conclusion of the insurance contract to the policyholder by issuance and delivery of the policy.
4. Unless mentioned otherwise in the insurance contract, start of the insurance occurs on the first day after conclusion of the insurance contract. Unless mentioned otherwise in the proposal for change in the insurance contract, the start of insurance in case of an additionally arranged rider occurs on the first day after acceptance of the proposal for change in the insurance contract by the insurance company. The insurance starts at 0:00 of the day arranged as the start of insurance.
5. Unless set otherwise by the insurance contract, the proposal for change in the insurance contract must be submitted in writing. The policyholder usually submits the proposal on the prescribed form that is available at the websites of the insurance company or at the relevant insurance broker of the insurance company. The proposal for change in the insurance contract must be delivered to the insurance company latest 2 working days before its effective date. The insurance company is entitled to charge the fees mentioned in the overview of charges for a change in the insurance contract.
6. Some changes in the insurance contract that are connected with premium payment or that have an influence on its level may be done only with effect as of premium maturity date in dependence on the arranged insurance period (monthly, quarterly, etc.) or only as of the anniversary date. If the insurance company accepts these changes, their effect occurs on the nearest maturity day of regular premium, which follows after delivery of the proposal for change in the insurance contract to the insurance company unless the contract parties agree otherwise.
7. The insurance company will carry out the proposed change without an unnecessary delay or it will deny realisation of the change while mentioning the reasons or it will present a relevant counter-proposal. If it is not possible to perform the change without an unnecessary delay because it can be done only as of a certain date or due to a debt on premium, the insurance company will postpone the effect of the requested change in a corresponding way. The insurance company will inform the policyholder about this fact without an unnecessary delay after delivery of his/her request. The insurance company will send the new policy to the policyholder after realisation of the change. Earlier issued policies lose validity by sending of the new policy.
8. The insurance cannot be interrupted unless special insurance conditions set otherwise.

Article 4 - What is understood by premium and which facts influence its level?

1. Premium is a consideration for provided insurance protection and its amount is mentioned in the insurance contract. The insurance company is entitled to premium for the period of the insurance duration.
2. **If an insured event occurred, due to which the insurance lapsed, premium belongs to the insurance company until the end of the insurance period when this insured event occurred. In such a case single premium belongs to the insurance company for the whole period, for which the insurance was arranged.** If the insurance lapses due to another reason before expiry of the insurance period, for which premium has been paid, the insurance company is obliged to return the proportional part of prepaid premium to the policyholder and this decreased by possible charges and costs of the insurance company. It is similarly valid also for single premium.
3. The amount of premium is determined according to insurance mathematical methods valid for individual kinds of life insurance (main coverage) and riders and this in compliance with the principle of equal treatment. The insurance company is obliged to advise the principles for determination of the amount of relevant premium upon a written request by the policyholder delivered to the insurance company.
4. **The policyholder or the insured person has to notify the insurance company of all changes in facts that were mentioned in the insurance contract or that the insurance company asked about, which lead to a change or lapse of insurance risk, then above all changes in work, business, sports or other interest activity of the insured person, without an unnecessary delay, however, latest within a month from the day when they occurred. If the policyholder or the insured person violates the obligation to notify the insurance company of increased risk, the insurance company is entitled to cancel the insurance without a notice period within 2 months from the day when it learned about the increase in insurance risk. In such a case premium belongs to the insurance company up until the end of the insurance period, in which the insurance lapsed; in this case the entire single premium belongs to the insurance company.**
5. If a change in facts that were mentioned in the insurance contract or that the insurance company asked about, then above all changes in work, business, sports or other interest activity of the insured person, significantly decreases the insurance risk according to the tariff of charges valid at the moment of the change, the insurance company is obliged to decrease premium according to it proportionally to the decrease in insurance risk and this with effect from the nearest maturity day of premium following after the day when the change was announced to the insurance company.
6. If a change in facts that were mentioned in the insurance contract or that the insurance company asked about, then above all changes in

work, business, sports or other interest activity of the insured person, increases the insurance risk according to the tariff of charges valid at the moment of the change, the insurance company is entitled to propose to the policyholder a new amount of premium according to it corresponding with the increased insurance risk. In such a case the insurance company delivers a written proposal of the new premium amount to the policyholder latest within a month from the day when the mentioned change in facts has been announced to it. If the policyholder does not agree with the proposal of the insurance company, he/she is obliged to deliver a written notification to the insurance company latest within 15 calendar days from delivery of the insurance company's proposal that he/she denies the proposal. **It the policyholder does not do so, it is assumed that he/she confirms his/her approval with the new amount of premium as of the day following after expiry of the mentioned period. Then the change in premium proposed by the insurance company becomes effective from the nearest maturity day of premium, which follows after expiry of the mentioned period. However, if the policyholder delivers a written notification to the insurance company within the mentioned period of 15 calendar days that he/she denies the proposal, the insurance company is entitled to cancel the insurance contract as a whole or the relevant rider(s) within 2 months from receipt of the disapproval with a notice period of eight days after delivery of the notice to the policyholder.** The policyholder will be warned of the possibility of notice in the proposal of the insurance company.

Provisions of this Article relate to all insurance types of persons including insurance of disease.

7. In justified cases the policyholder may be acknowledged a discount on premium or another authorisation connected with his/her insurance due to affiliation to a certain group (e.g. employer or given by a certain premium level) by the insurance company. The conditions for affiliation to a group are set by the insurance company. If a discount on premium or another authorisation is acknowledged to the policyholder due to affiliation to a certain group, the claim to this discount or authorisation ceases to exist as soon as his/her affiliation to this group is terminated. The conditions for provision of the discount on premium or another authorisation in question only change in the corresponding way in case of connected transfer to another group with termination of affiliation to the original group. In both these cases the policyholder is obliged to provide necessary collaboration to the insurance company in relation to the new setting-up of the insurance contract, especially as regards the arranged amount of premium.

Article 5 – When and how should I pay premium?

1. The policyholder is obliged to pay the premium arranged in the insurance contract properly and in time. Premium, which has been credited in favour of the insurance company's account determined by the insurance company, is understood as properly paid premium, and this in the amount, currency and period set in the insurance contract and/or in insurance conditions or in the reminder of premium payment, and with correct identification data of payment set by the insurance company (especially with the correct variable symbol). The insurance company can further set, in which cases it is possible to pay premium in another way. The date of premium placement to the account of the insurance company determined for premium payments by the insurance company is not identical with the date of premium placement in favour of the insurance contract. Regular premium can be paid in monthly, quarterly, bi-annual or annual insurance periods, and this in the way agreed in the insurance contract.
2. The first regular premium is payable by the day of the insurance start. Regular premium for the second and further insurance periods is payable as of the day of this period's start. Single premium is payable by the day of the insurance start.
3. If the policyholder does not pay the arranged premium properly and in time, the insurance will lapse due to non-payment of premium according to the conditions mentioned in Art. 7 paragraph 3 of these GTC. If special insurance conditions set so, also transfer of insurance into repaid status may be the result of non-payment of premium. It is specified in the relevant special insurance conditions, what is understood by insurance in repaid status and under which conditions insurance can be transferred into repaid status.
4. The insurance company is entitled to set a minimum and/or maximum limit for regular premium. It is similarly valid also for additional premium if special insurance conditions admit its payment above the scope of regular premium. Payment of additional premium neither has an influence on the policyholder's obligation to pay regular premium nor on the level of the sum assured.
5. If the insurance company receives a payment that cannot be identified (especially due to incorrect variable symbol), it is entitled to return it back without further examination to the bank account or to the address of the sender, from which it was paid in favour of the insurance company. It is similarly valid that if the level of minimum/maximum limit for additional premium set by the insurance company is not kept at payment of additional premium. The procedure for case when the policyholder does not determine at payment of additional premium, into which funds and in which ratio additional premium should be invested (so-called allocation ratio), is specified in special insurance conditions.
6. If regular premium is paid in an amount exceeding the amount of premium arranged in the insurance contract, **the difference between the amounts will be considered as deposit (advance payment) of premium for the next period. If regular premium is paid in lower amount than the amount of regular premium arranged in the insurance contract, a debt arises at the insurance contract on the level of the entire arranged regular premium for the actual insurance period and the paid amount is recorded as an overpayment at the insurance contract. At the moment when the overpayment at the insurance contract achieves the level of the debt on regular premium for the relevant insurance period, this debt is automatically settled from the overpayment.**
7. If the policyholder is in a delay with premium payment, any premium payment is always used for settlement of the oldest outstanding premium unless the policyholder and the insurance company agree otherwise.
8. All payments made in connection with the insurance contract, no matter whether by the policyholder or by the insurance company, will be done in the Czech currency unless agreed otherwise in the insurance contract.

Article 6 - What does the so-called anti-inflation programme mean and how does it influence the insurance?

1. **If the anti-inflation programme is arranged in the insurance contract, the insurance company always increases regular premium along with the increase in the sum assured of the insurance as well as of the riders as of the anniversary.** The insurance company notifies the policyholder of the new premium amount and the new sum assured sufficiently in advance before the anniversary, as of which the increase is supposed to be done.
2. Premium is increased by the same number of percent as the inflation rate enunciated by the Czech Statistical Office for the period of 12 calendar months that terminates three months before the anniversary day. In case when the inflation rate is lower than 5 %, premium will be increased by 5 %.
3. The sum assured will be increased along with the increase in regular premium in a corresponding way (in compliance with the relevant premium rate set for the given type of insurance or rider by the tariff of charges). The insurance company will calculate the increase in the sum assured according to insurance mathematical methods. The insurance company neither examines the health status of the insured person nor of the policyholder at this increase in the sum assured.
4. The insurance company may set maximum values (limits) of sums assured for the insurance and riders that cannot be exceeded at the increase in the sum assured according to paragraph 3 of this Article. The sum assured can be increased to the value of this limit at the most. The new premium will be determined according to this limit for the sum assured by insurance mathematical methods.
5. The policyholder is entitled to individually deny the increase in premium and in sum assured for each relevant year of the anti-inflation programme duration, and this within a period that is set in the notification of the new level of premium and the sum assured by the insurance company.
6. The anti-inflation programme automatically lapses:
   a) By the day, from which the policyholder is exempt from the obligation to pay regular premium, or
   b) By the day of the insured event if this insured event is a disease, or
   c) By the day when disability of degree III is acknowledged to the insured person by the insurance company.
7. The anti-inflation programme can also lapse on the basis of arequest by the policyholder for its cancellation. Such cancellation of the anti-

inflation programme will become effective starting by the first anniversary that will follow after the delivery of the policyholder's request to the insurance company.

Article 7 - In what situations and as of which moment does the insurance lapse?

1. The insurance lapses especially due to the following reasons:
   a) By an insured event unless set otherwise in special insurance conditions;
   b) By expiry of the arranged duration of cover;
   c) Due to non-payment of premium;
   d) By notice;
   e) By withdrawal;
   f) By denial of benefit payment according to paragraph 7 of this Article;
   g) By payment of surrender;
   h) By agreement;
   i) If the insurance interest ceases to exist during the insurance duration.
2. If the reason for lapse of insurance is an insured event, the insurance lapses as of the date of the insured event's rise. If the reason is expiry of the arranged period, the insurance lapses at 24.00 of the day arranged as end of the insurance.
3. In case of the insurance lapse due to non-payment of premium the insurance lapses by the vain expiry of the period for payment of outstanding premium that the insurance company set in the reminder sent to the policyholder; this period will not be shorter than one month. The policyholder will be warned of the possibility of insurance lapse in the reminder.
4. Cancellation of insurance can be done especially in the following ways:
   a) The policyholder may cancel the insurance in writing as of the end of the insurance period; such a notice must be delivered to the insurance company at least 6 weeks before expiry of the insurance period. If the notice is delivered later, the insurance lapses as of the end of the following insurance period. The insurance company may cancel the insurance under identical conditions with the exception of life insurance policies that cannot be cancelled.
   b) The insurance company or the policyholder may cancel the insurance within 2 months from the day of the insurance contract conclusion with the notice period of eight days after delivery of the notice to the other contract party. The insurance lapses by expiry of the notice period.
5. Withdrawal from the insurance contract is possible due to the following reasons:
   a) If the policyholder or the insured person intentionally or negligently answers the written questions of the insurance company concerning the arranged insurance (or more precisely facts that are important for the decision of the insurance company how to assess the insurance risk, whether to insure the person interested in the insurance and under what conditions) wrong or incompletely at the arrangement of the insurance contract, the insurance company has the right to withdraw from the insurance contract if it would not have concluded the insurance contract in case of truthful and complete answers to the questions. The insurance company may apply this right within 2 months from the day when it found out such a fact, otherwise the right lapses. This is valid also in case of a change in the insurance contract.
   b) The policyholder has the right to withdraw from the insurance contract if the insurance company or its insurance broker answered his/her written questions concerning the arranged insurance wrong or incompletely. The policyholder has the same right if the insurance company or its insurance broker did not call his/her attention to discrepancies between the offered insurance and the policyholder's requirements that the insurance company must have been aware of.
   c) The policyholder has the right to withdraw from the insurance contract also without mentioning a reason within the period of 30 calendar days from the day of the insurance contract conclusion. In case of the insurance contract conclusion through remote communication means, this period is calculated from the day when the policyholder was informed by the insurance company that the insurance contract had been concluded.
6. The insurance contract is cancelled from the beginning by withdrawal from the insurance contract. The insurance company is obliged to return the paid premium, from which already paid benefit from the insurance will be deducted, latest within the period of 30 calendar days from the day of withdrawal from the insurance contract. In case of the insurance company's withdrawal from the insurance contract, also costs connected with rise and administration of insurance will be deducted from the paid premium. The policyholder or the insured person who is not the policyholder at the same time, or the second beneficiary as the case may be, is obliged to return to the insurance company the amount of paid benefit exceeding the amount of paid premium within the same period.
7. The insurance company can deny benefit payment resulting in lapse of insurance if the following three conditions have been met concurrently:
   a) The reason for the insured event was a fact, about which the insurance company learned only after the rise of the insured event, and
   b) That the insurance company could not have found out at the arrangement of insurance or at its change, and this due to the fact that the policyholder and/or the insured person intentionally answered the written questions of the insurance company wrong or incompletely, and
   c) If the insurance company would not have concluded this contract if it knew about this fact at the time of the insurance contract conclusion or it would have concluded it under different conditions.

   The insurance lapses by the day of the notification delivery of benefit payment denial according to this paragraph. The insurance company does not return the paid premium.
8. If set so by special insurance conditions, the policyholder has the right to lapse of insurance with payment of surrender upon his/her written request. Then the surrender is payable latest within 3 months from the day when the policyholder's request has been delivered to the insurance company. The insurance lapses by payment of surrender. The insurance company sets the amount of surrender on the basis of insurance mathematical methods whereas the actual way of the surrender level calculation is specified in the relevant special insurance conditions. The amount of surrender is not equal to the summary of paid premium.
9. If the policyholder differs from the insured person and if it is not a group insurance, a written approval of the insured person is requested for payment of surrender.
10. The law or special insurance conditions may set also other ways of insurance lapse.
11. If insurance of the main coverage lapses, also arranged riders lapse by the day of its extinction. Riders can be cancelled or terminated also independently or otherwise unless set otherwise by special insurance conditions.

Article 8 - Who is entitled to benefit payment, how to ask for it and how will it be paid?

1. In case of an insured event, with exception of the insured person's death, the beneficiary is the insured person unless set otherwise by special insurance conditions or by the insurance contract.
2. If the insured event is the insured person's death, the policyholder can determine a second beneficiary as the beneficiary. The policyholder can change the second beneficiary up until the rise of an insured event. A change of the second beneficiary is effective by the day of delivery of the written announcement to the insurance company. If no second beneficiary was set at the time of the insured event or if the second beneficiary does not acquire the right to benefit payment, persons set by valid legal regulations acquire this right.
3. The policyholder is obliged to do the following without an unnecessary delay in case of an insured event's rise:
   a) To report occurrence of the insured event;
   b) To provide truthful explanation about the rise and scope of consequences of this event, about rights of third parties and about any multiple insurance;
   c) To submit the necessary documents;
   d) To undergo a medical examination and obligatory identification upon the call by the insurance company;

e) To announce data necessary for realisation of benefit payment and
f) To further proceed in the way agreed in the insurance contract.

If the policyholder is not the insured person at the same time, the insured person has these obligations. If the insured event is the insured person's death, the second beneficiary has these obligations. The same notification can be also made by any person having a legal interest in benefit payment. **An insured event is reported on the prescribed "Claim notification" form of the insurance company.** The insurance company will not pay the benefit or it will not start with payment of an annuity or it will stop their payments until these obligations have been fulfilled by the beneficiary. The insurance company keeps the documents submitted within notification and investigation of the insured event.

4. If the insured event is living until the arranged end of insurance, benefit payment is payable within a month from the insured event's day. In case of other insured events, benefit payment is due within 15 working days after termination of the investigation necessary for identification of the scope of the insurance company's obligation to pay the benefit. The investigation must be carried out without an unnecessary delay and if it cannot be finished within 3 months after the claim's notification to the insurance company, the insurance company is obliged to provide an adequate advance payment upon the request of the person applying the right to benefit payment. This is not valid if there is a reasonable reason for denial of advance payment provision. The investigation is terminated as soon as the insurance company announces its result to the person applying the right to benefit payment.
5. The insurance relates to insured events that occur anywhere during the insurance duration unless set otherwise by special insurance conditions. Special insurance conditions specify more details, what is understood by an insured event and when the obligation of the insurance company to provide benefit payment arises. An accident or a disease, whose result is an insured event, must occur during the insurance/rider's duration and eventually also after expiry of the arranged waiting period if the waiting period is set in special insurance conditions for the rider.
6. The insurance company is not obliged to provide benefit payment if the insured person recalled his/her approval to the insurance company that the insurance company may request data about his/her health status, investigate his/her health status or reason of his/her death, granted in the sense of Act No. 89/2012 Coll., the Civil Code, and this up until the time before such approval is granted again.
7. If the notification to the insurance company contains consciously wrong or grossly distorted essential data concerning the scope of the reported insured event or if data concerning this event are consciously concealed, the insurance company has the right to compensation of costs, which it purposefully expended for investigation of facts, in relation to which these data were reported or concealed. It is assumed that the insurance company expended the costs on the proven level purposefully. If the policyholder, the insured person or another person applying the right to benefit payment causes costs for investigation or their increase by violation of his/her obligation, the insurance company is entitled to require adequate financial compensation from this person.
8. The insurance company is entitled to offset the outstanding premium and any other of its receivables from the insurance against the receivable from benefit payment. **The insurance company is entitled to offset also her already statute barred receivables from the insurance against a receivable from benefit payment.**
9. **If an overpayment is recorded at the insurance contract, the insurance company is entitled to settle such an overpayment in the form of its adding to the benefit payment**.

Article 9 - When is the insurance company entitled to decrease the paid benefit?

1. **The insurance company is entitled to decrease benefit payment according to the circumstances in any of the following cases:**
   a) **If the insured person died in connection with a neglectful act, by which he/she caused a severe injury or death to another person,** and this by 50 % at the most,
   b) If the insured person died in connection with an intentional act, by which he/she caused a severe injury or death to another person, and this at least by 50 %,
   c) If the insured event occurred in connection with alcohol consumption or application of narcotic or psychotropic substances by the insured person including misuse of a medicament by the insured person or if the insured event occurred due to repeated alcohol consumption or repeated application of the mentioned substances by the insured person or in connection with them, and this by 50 % at the most,
   d) **If the insured event occurred due to gross violation of legal regulations that the insured person was obliged to keep at the activity, due to which the insured event occurred or in connection with it,** and this by 50 % at the most.
2. **If lower premium was arranged at the negotiation about an insurance contract conclusion or about its change due to the violation of a policyholder's or insured person's obligation, the insurance company has the right to decrease benefit payment by such a part, as represented by the proportion of premium, which it received, to the premium that it was supposed to receive.**
3. **If violation of an obligation of the policyholder, the insured person or another person having the right to benefit payment had a substantial influence on the insured event's rise, its course, increase of the scope of its consequences or on identification or determination of the level of benefit payment, the insurance company has the right to decrease the benefit payment proportionally to the fact, what influence this violation had on the scope of the insurance company's obligation to provide benefit payment.**
4. **If an insured event occurs during the period between an increase in the sum assured and crediting of the first premium increased on the basis of this change in favour of the insurance company's account, the insurance company is entitled to decrease the benefit payment to the sum assured valid before the effective date of the change in the insurance contract. This is not valid if the change in the insurance contract occurred in connection with the anti-inflation programme.**
5. **If an insured event occurs at notification of an increase in the insurance risk during the period between the day when the increased premium proposed by the insurance company is considered as approved by the policyholder and the effective day of this change including crediting of the first premium increased on the basis of this change in favour of the insurance company's account, the insurance company is entitled to decrease the benefit payment proportionally to the situation, what is the ratio of the premium, which it received, to the approved increased premium according to the increased insurance risk. If the policyholder or the insured person violates the obligation to report increase in the insurance risk and if an insured event occurred after this change, the insurance company is entitled to decrease benefit payment proportionally to the situation, what is the ratio of the premium, which it received, to the premium that it should have received if the obligation to report an increase in the insurance risk has not been violated.**
6. **The insurance company is entitled to decrease the benefit payment also in other cases according to the circumstances set by special insurance conditions or by valid legal regulations.**

Article 10 - Which cases does the insurance not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in case of the insured person's death due to a suicide or an attempt for it during the period of 2 years from the insurance start.** If the policyholder had a claim to surrender as of the date of the insured person's death according to special insurance conditions, the insurance company will pay the amount corresponding to the surrender value to the beneficiary instead of the benefit for case of death. In the opposite case the insurance lapses by the insured person's death without compensation. **If the insured person died as result of a suicide or an attempt for it during 2 years after any increase in the sum assured, the insurance company is entitled to decrease the benefit to the lowest sum assured valid for the last 2 years before his/her death**.
2. **The right to benefit payment does not arise in case of a claim event caused due to or in connection with a war event, rebellion, uprising, revolution events, coups, international peace mission or at performance of active service in any military forces if the service is performed at extremely risky activities such as foreign missions in crisis areas with a threat of or with an ongoing armed conflict (declared by the Ministry of Foreign Affairs of the Czech Republic), performance of service during war, civil war and similar extraordinary conditions. If the claim event is death and the policyholder would have a claim to surrender as of the insured person's death according to special insurance conditions, the insurance company will pay the**

amount corresponding to the surrender value to the beneficiary instead of the benefit for case of death. In the opposite case the insurance lapses by the insured person's death without compensation.

3. **The right to benefit payment does not arise:**
   - **a) If the beneficiary and/or the insured person (if the beneficiary is another person than the insured) has been found guilty of an intentional criminal offence by a final decision of a court in connection with the insured event, or**
   - **b) If in connection with the above-mentioned facts prosecution towards them has not been initiated due to its impermissibility or due to irresponsibility of the beneficiary and/or of the insured person (if the beneficiary is another person than the insured) or this prosecution has been stopped, conditionally stopped, interrupted or a settlement has been achieved.**

   If bodies active in criminal proceedings lead preparatory proceedings or prosecution against the policyholder, insured person or beneficiary in connection with the insured event or with the insurance, the insurance company is not obliged to pay the benefit and this up until a final decision has been issued in this matter.
4. **The right to benefit payment does not arise in case when the beneficiary mentions consciously wrong or grossly distorted data concerning the scope of the insured event or conceals substantial data concerning this event when applying the right to benefit payment.**
5. The right to benefit payment does not arise if the insured event was intentionally caused by the person applying the right to benefit payment or if the insured event was intentionally caused by a third party on the basis of his/her suggestion.
6. The right to benefit payment does not arise if disability occurred in direct or indirect connection with:
   a) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;
   b) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;
   c) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent.
7. **Further exclusions from benefit payment are set by special insurance conditions or by valid legal regulations.**

Article 11 - What other rights and obligations are connected with insurance?

1. **The policyholder or the insured person is obliged to notify the insurance company of all changes in facts that are mentioned in the insurance contract or that the insurance company asked about, which occur during the insurance/rider's duration. The policyholder will provide this information without unnecessary delays, however, latest within a month from the day when the relevant change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal and contact data (e.g. permanent residence, contact address), name, E-mail or telephone number) and change in other data mentioned in the insurance contract or connected with insurance/riders (e.g. change in work, business, sports or other interest activity, decision concerning disability, acknowledgement of old age pension or other circumstances that have an influence on the insurance risk or existence of insurance interest). This obligation similarly applies also to the insurance company in relation to the policyholder**.
2. Written questions of the insurance company concerning the arranged insurance or more precisely facts, which are important for the decision of the insurance company how to assess the insurance risk, whether to insure the person interested in insurance and under what conditions, including questions about the health status of the insured person, are a part of the insurance contract. The insurance company is entitled to ask these written questions not only at the conclusion of the insurance contract but also at each change in respect thereof whereas the insurance company examines the health status of the insured person also within investigation of an insured event. The policyholder as well as the insured person is obliged to answer all questions truthfully and completely. The same is valid also for the second beneficiary or any other person having a legal interest in benefit payment. If he/she intentionally or negligently answers the questions wrong or incompletely, the result may be withdrawal of the insurance company from the insurance contract, denial or decrease of benefit payment. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire (unless it is replaced by an affidavit on health status) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor directly by the insurance company or through a health centre entrusted by it. Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. **in justified cases the insurance company is entitled to check the insured person's health status by a doctor appointed by itself.**
3. If the policyholder granted his/her approval with electronic communication, this approval is granted also in compliance with provision of § 7 paragraph 2 of Act No. 480/2004 Coll., on Certain Information Society Services and on Amendments to some Acts, in the wording of later regulations, to use of details of his/her electronic contact (email address) for the purpose of dissemination of the insurance company's commercial communication.
4. The insurance company is entitled to ask authentication of the policyholder's and/or insured person's and/or beneficiary's signature at performance of certain acts connected with the insurance in compliance with valid legal regulations and in the interest of rights' protection of the policyholder and of the insured person or perhaps even to perform identification and checking of this person in the sense of Act No. 253/2008 Coll., on Certain Measures against Money Laundering and Financing of Terrorism, verification of his/her identity or to require a photocopy of his/her identity card if need be.
5. The insurance company reserves the right to verify the submitted documents as well as the right to require expert opinions by specialists, whom it will appoint itself. The insurance company is also entitled to consult complicated insured events or send them for professional judgement and this still before provision of benefit payment.
6. The insurance company is also entitled to require from the policyholder or from the insured person documents about the level of income and length of wage payment or its compensation from the employer. If the insurance company requires a proof of the policyholder's or of the insured person's gross income, the amount corresponding to the definition of gross income mentioned in Art. 14 of these GTC, is understood by it. Gross income is proven by a confirmation of the wage payer about income of the policyholder or the insured person as an employee for the period of 3 calendar months following one after another prior to the day of the insurance start or of the insured event's rise and if the policyholder or the insured person is not an employee, he/she submits an authenticated copy of the tax return for the last 1 to 2 taxation periods antecedent to the day of the insurance start or the insured event's rise.

Article 12 - What rules are valid for delivery of documents and way of communication with the insurance company?

1. **Exclusively delivery to the seat of the insurance company is understood by delivery to the insurance company.** Documents (i.e. notification, request or any other submission addressed to the insurance company) must be complete and meet formal and content terms set by legal regulations and by the insurance contract. **If a document is incomplete or with defects,** the insurance company will call on the person that submitted the paper to amend the missing data or remove its defects without an unnecessary delay. In these cases **only the delivery day of all missing data and removal of all defects in documents is understood as the day of delivery.**
2. A document, which the insurance company delivers to the policyholder, insured person or beneficiary, through an operator of postal services is sent to the contact address mentioned in the insurance contract or to the address last known to the insurance company. **Postal shipments are considered as delivered by the seventh calendar day since the day of their sending unless another delivery date is proven.**
3. It is valid for personal delivery that effects of delivery occur by the moment of the shipment's takeover by the other contract party. The

contract party is obliged to confirm this takeover and the takeover date in writing on a copy of the delivered paper or on its duplicate.

4. If a contract party denies takeover of a document or if it does not provide collaboration necessary for it, the contract parties agreed that a document is considered as delivered by the day when delivery of the document was disabled due to these reasons.
5. Delivery of any papers is possible also through a courier service that enables delivery verification. Papers sent in this way are considered as delivered by the moment of their takeover by the other contract party.
6. Unless the insurance contract sets otherwise, all notifications, announcements, requests or any other submissions, which are addressed to the insurance company in relation to the insurance, are made in writing, usually on the prescribed form that is available at the websites of the insurance company or at the relevant insurance broker of the insurance company. The insurance contract may set, in which cases it is possible to use also another form for communication between the contract parties, above all E-mail or telephone contact.
7. **The requirement of written form will be also considered as fulfilled if the relevant act is realised by the policyholder or by the insured person through the self service portal of the insurance company.** The insurance company will communicate with the policyholder through the self service portal only in case that the policyholder is a properly registered user of the self service portal and his/her insurance contract is recorded in the self service portal. It will be possible to perform selected changes in the insurance contract including conclusion of a new insurance contract to selected types of insurance through the self service portal of the insurance company in some cases. The contract parties agreed **that at communication through the self service portal a document sent by the policyholder is considered as delivered by the moment when the self service portal creates a message about its sending and a document sent by the insurance company is considered as delivered by the moment when it is displayed in the environment of the self service portal as a new message. If the policyholder delivers a document to the insurance company through the self service portal on a day, which is not a working one, the document is considered as delivered on the nearest following working day.**

Article 13 – What other important rules of insurance are necessary to know?

1. The decisive law for the insurance contract is the legal order of the Czech Republic. All disputes connected with insurance or resulting from it will be resolved by the relevant court of the Czech Republic or by another relevant body in compliance with valid legal regulations of the Czech Republic.
2. In case that some arrangement of the insurance contract and/or insurance conditions becomes or is found invalid or unenforceable, it will not influence (in the maximum possible scope admissible according to relevant legal regulations) the validity and enforceability of the remaining provisions of the insurance contract and insurance conditions. In such a case, the arrangement in question will be replaced by a valid and enforceable provision that will be equal to the original one and the significance and effect admissible by legal regulations will follow the originally intended arrangement to the highest possible level.
3. If the policyholder or the insurance company is in a delay with payment of a monetary amount, the party, which is not delayed with fulfilment of its obligation, has the right to an interest for delayed payment on the level set by legal regulations. The period necessary for investigation of an insured event is not considered as a delay of the insurance company with benefit payment.
4. If a period is set for a certain act in the insurance contract, insurance conditions and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. **The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems**.
5. If the policyholder/insured person announces a change in some of the following identification/personal data – surname, name, title, gender, birth number (issued in CR), place of permanent residence, state citizenship, or data about identity document (especially its number, who issued it and until when it is valid), the insurance company is entitled to secure updating of these data also in all other contracts, which the policyholder/insured person has concluded with the insurance company.
6. The insurance company is entitled to carry out unilateral change in the business name of a product or service, about which it is obliged to inform the policyholder in an appropriate way and without an unnecessary delay. A change in the business name of a product or service does not impact the rights and obligations of the contract parties resulting from the insurance contract, therefore the contract parties do not consider such a change as a change in the contract about the given product or service.
7. **The insurance company has the right to perform an adequate change in these insurance conditions and/or in the tariff of charges or in the overview of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of the insurance conditions to the policyholder to the last known contact address; if it is a change in the tariff of charges or in the overview of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of the insurance conditions to the policyholder and/or publishing of the new wording of the tariff of charges or overview of charges and the effective day of this change. The policyholder has the right to deny the change concerning the arranged main coverage and at the same time to cancel the insurance contract in such a case. The notice period represents 20 calendar days from the day of the written notice delivery to the insurance company. **If the policyholder does not deliver a written notification to the seat of the insurance company latest 30 calendar days before the effective date of the change that he/she denies the change and cancels the insurance contract at the same time, he/she confirms his/her approval with the change in the insurance conditions and/or in the tariff of charges or overview of charges by this in the wording, in which it was proposed by the insurance company. If the change concerns only the arranged riders, the procedure mentioned in special insurance conditions to these riders is valid for these cases.**
8. The relevant entity for out of court solution of consumer disputes in connection with life insurance is the Financial arbitrator, www.finarbitr.cz. You can also use the on-line Platform for solution of consumer disputes https://webgate.ec.europa.eu/odr/ for solution of a dispute from a contract concluded on-line (i.e. through website or other electronic means).
9. These general insurance conditions for life insurance become effective on April 15, 2018.

Article 14 - Vocabulary of terms – what terms are important for me?

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims, does not arise to the insurance company.

Main coverage
Insurance provided by the insurance company as the main life insurance.

Gross income
Amount corresponding to the gross salary (if it is an employee) and/or income from business activity or from another independent gainful activity after deduction of expenditures according to the tax return for the past taxation period (if it is not an employee).

Additional premium
Premium paid above the scope of regular premium arranged in the insurance contract for the purpose of increase in the investment component of life insurance.

Disease (disorder):
Health disorder of the insured person that can be a reason for rise of an insured event or whose occurrence during a rider's duration is defined directly as an insured event in special insurance conditions.

Second beneficiary
Person determined by the policyholder, to whom the right to benefit payment arises in case of death of the insured person.

Beneficiary
Person entitled to benefit payment due to an insured event.

Sum assured
Amount, whose payment is arranged in the insurance contract for case of an insured event's rise.

Duration of cover
Period, for which insurance was arranged in the insurance contract determined by the date of insurance start and the date of its end (so-called insurance for definite period) or only by the date of insurance start (insurance for indefinite period). If the end of the duration of cover is set to a certain age of the insured person in the insurance contract, the anniversary date in the calendar year, in which the insured person achieves this age, is understood as the date of the insurance end.

Insured event
Incidental event designated in the insurance contract, which occurred during the insurance duration and that rise of the insurance company's obligation to provide benefit payment is connected with.

Premium
Consideration for insurance that can have the nature of consideration for the arranged insurance period (so-called regular premium) or consideration for the whole duration of cover, for which insurance was arranged (so-called single premium).

Insurance period
Time period, for which regular premium is paid (so-called frequency of payments).

Benefit payment
Amount, which the insurance company will pay after termination of the insured event's investigation, whose level will be determined in compliance with the insurance contract on the basis of the results of investigation.

Insurance conditions
These general insurance conditions and special insurance conditions for the arranged type of insurance and/or riders.

Policyholder
Natural or legal person that concluded an insurance contract.

Insurance year
Period of twelve months following from the insurance start until the date of the first anniversary and further on the periods among the dates of anniversaries following one after another.

Insurance interest
Rightful need of protection from consequences of an insured event.

Insured person
Natural person, whose life or health the insurance relates to.

Insurance company (insurer)
NN Životní pojišťovna N.V., branch office for the Czech Republic, seated at: Nádražní 344/25, 150 00 Praha 5 – Smíchov, ID No.: 4076358, entered in the trade register maintained by the City court in Prague, Section A, Insert 6305, as organisational unit (branch) of the company: NN Životní pojišťovna N.V., seated at: Weena 505, 3013AL Rotterdam, the Kingdom of the Netherlands, entered in the trade register of the Chamber of Commerce in Rotterdam, the Kingdom of the Netherlands, date of entry is January 17, 1863, entry No. 24042211.

Overview of charges
Document, which sets the charges paid to the insurance company by the policyholder for individual kinds of the main coverage, their amounts and also so-called technical limits for individual operations; the topical wording of the overview of charges is available at the websites of the insurance company or in the seat of the insurance company; wording valid as of the day of the insurance contract conclusion is also a part of Pre-contractual information.

Rider
Insurance that the insurance company is entitled to offer as supplementary insurance of a disease or an accident to the main life insurance (main coverage).

Tariff of charges
The insurance company's tariff of charges where premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders are mentioned; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Claim event
Incidental event that could be the reason for rise of an insured event and that could establish the right to benefit payment from insurance and/or riders to it.

Accident
Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident.

GTC
These General insurance conditions for life insurance of NN Životní pojišťovna N. V., branch office for the Czech Republic.

Age at entry
Difference between the calendar year of the insurance start and the calendar year when the insured person was born.

Anniversary
Anniversary day of the insurance start in each calendar year of the period of insurance duration.

Life insurance
All Main coverages and riders for case of death, disability, cancer, sever diseases, waiver of premium payment as a result of a disease or accident and long term care rider for cases that are result of a disease or accident

SPECIAL INSURANCE CONDITIONS FOR INSURANCE OF TYPE UNIT LINKED INSURANCE NN SMART UZ3C

Article 1 - Which legal documents are important for me and how to use them?

These special insurance conditions for Unit Linked Insurance NN Smart UZ3C (hereinafter only "SPC Smart") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (GTC).

Article 2 - What is the scope of insurance?

This insurance can be arranged in the scope of one or two natural persons (first and second insured persons). It is created by the main coverage, to which one or more optional riders may be arranged for the first insured person and/or second insured person and/or child rider under conditions set by the insurance contract. The insurance company will set the minimum scope of this insurance (including possible riders arranged to it) in the tariff of charges in the form of the minimum premium level determination and this for the insurance contract as a whole and further individually for the main coverage of the first insured person and for other insurance coverages (i.e. for the main coverage of the second insured person and all riders of both insured persons).

Article 3 - What is covered by the insurance and what benefit payment am I entitled to in case of a claim?

1. Insurance of the following claims is arranged within this insurance:
   a) Death of the first insured person at the period of insurance duration after reaching the age of three years,
   b) Reaching the arranged end of insurance by the first insured person,
   c) Death of the second insured person at the period of the insurance duration.
2. In case of a claim according to paragraph 1 letter a) of this Article the insurance company will pay the benefit to the beneficiary in the amount of the sum assured for case of the first insured person's death valid as of the day of the claim's rise or in the amount of the unit account's value in the status as of the day of the claim's rise if this value is higher than the mentioned sum assured – so-called "Higher from" option.
3. If the first insured person dies before reaching the age of three years, the insurance lapses as of the day of his/her death (as a whole). In such a case the insurance company will pay the value of the unit account in the status as of the date of death to the policyholder.
4. The selling price latest from the nearest appraisal day after the day, when the insurance company is delivered the notification of claim or notification of the first insured person's death before reaching the age of three years, is used for calculation of the unit account's value according to paragraphs 2 and 3 of this Article.
5. In case of a claim according to paragraph 1 letter b) of this Article the insurance company will pay the benefit to the beneficiary in the amount of the unit account's value in the status as of the day of the claim's rise. The selling price latest from the nearest appraisal day after the day of the claim's rise will be used for calculation of this value.
6. In case of a claim according to paragraph 1 letter c) of this Article the insurance company will pay the benefit to the beneficiary in the amount of the sum assured for case of the second insured person's death valid as of the day of the claim's rise.
7. The insurance contract lapses by a claim according to paragraph 1 letters a) and b) of this Article. This is not valid if the second insured person enters into the contract after the first insured person's death who was the policyholder at the same time, instead of him/her according to conditions set in Art. 4 of these SPC Smart. Only insurance of the second insured person (not the insurance contract as a whole) lapses by a claim according to paragraph 1 letter c) of this Article.
8. The second insured person may accede to the insurance contract as of any maturity date of regular premium in dependence on the arranged insurance period. Insurance coverage can be provided to him/her until the end of the first insured person's insurance duration at the most.
9. The insurance company is entitled to set the minimum scope of the second insured person's insurance in the tariff of charges independently (especially the minimum sum assured or the minimum premium amount).

Article 4 - What are the impacts of the death of the first insured person, who was the policyholder at the same time, on the second insured person?

1. If the first insured person, who is the policyholder at the same time, dies during the period of the insurance duration, which was arranged in the scope of two insured persons, the second insured person enters the position of the policyholder by the day of his/her death. At the same time the second insured person is obliged to notify the insurance company in writing within the period of 90 calendar days from this claim whether he/she is interested in extension of insurance coverage to the level of the first insured person under the conditions described in paragraph 2 of this Article and this with effect as of the day of the nearest premium maturity following after the death of the first insured person.
2. Change in the scope of the second insured person's insurance coverage is understood by extension of the second insured person's insurance coverage according to the previous paragraph in such a way that in case of the second insured person's death the insurance company will pay the benefit to the beneficiary on the level of the summary of the sum assured for case of the second insured person's death valid as of the claim's day and the unit account's value in the status as of the day of the claim's rise. The selling price latest from the nearest appraisal day after delivery of the claim's notification to the insurance company will be used for calculation of this value. The sum assured for case of the second insured person's death and the sums assured of all riders of the second insured person arranged in the insurance contract remain kept but the premium amount will change according to the second insured person's age (see other type of rate for determination of the risk premium's level) with regard to provision of Art. 9 paragraph 2 of these SPC Smart. If the condition for the minimum scope of this insurance, which is set in the tariff of charges in the sense of Art. 2 of these SPC Smart, is not met after this change, the present second insured person is obliged to increase the premium. If he/she does not do so, the insurance contract will lapse without compensation by the procedure according to paragraph 4 of this Article.
3. A new number will be assigned to the insurance contract at the procedure according to paragraph 2 of this Article.
4. **If the second insured person does not notify the insurance company in writing within the mentioned period of 90 calendar days since the death of the first insured person, who was the policyholder at the same time, of his/her interest in extension of the insurance coverage according to the first insured person, the insurance contract will lapse as a whole after vain expiry of this period and this retrospectively as of the day of the death of the first insured person who was the policyholder at the same time. The same is valid if the second insured person does not secure fulfilment of the condition of minimum scope of this insurance set in the tariff of charges in the sense of Art. 2 of these SPC Smart within the mentioned period or if he/she notifies the insurance company of the fact that he/she is not interested in further duration of the insurance contract (after the death of the first insured person who was the policyholder at the same time) in writing within the mentioned period.**

Article 5 - Under which conditions does the insurance company provide a loyalty bonus?

1. If the insurance contract meets the below described conditions, the insurance company will provide a so-called loyalty bonus to the policyholder. The following 3 basic conditions are set to gain a loyalty bonus:
   a) The sum assured of the Main coverage of the first insured person is arranged on the minimum level of 100 000 CZK.
   b) Any riders with minimum aggregate monthly premium in the amount of 400 CZK (after taking possible discounts on premium into account) are arranged to the insurance contract; CRDF waiver of premium payment rider of BNP Paribas Cardif Pojišťovna, a.s. is an exception, which is not included in the mentioned limit for minimum aggregate premium for the rider,
   c) Premium is paid properly.
2. A loyalty bonus on the level of 10 % from regular premium for all arranged riders prescribed and paid for the given insurance period is created for the policyholder for each insurance period, in which all above-mentioned conditions are met. CRDF waiver of premium payment rider of BNP Paribas Cardif Pojišťovna, a.s. (former POJIŠŤOVNA CARDIF PRO VITA, a.s.) is an exception, for which no loyalty bonus is acknowledged. The policyholder will be regularly informed about the topical value of the gained loyalty bonus and this always as of the anniversary date.

3. The topical value of the gained loyalty bonus as of the date of the tenth anniversary will increase the unit account's value in the form of an investment into the Guaranteed fund. Units of the Guaranteed fund will be purchased for the purchase price latest from the nearest appraisal day after the day of the tenth anniversary. Thus the loyalty bonus gained until this moment becomes a part of the unit account's value including the possibility of extraordinary withdrawal of units from the unit account. After this moment the policyholder has the possibility to gain a loyalty bonus again under the same conditions that means it will be proceeded accordingly after expiry of every further ten years of the insurance contract duration.
4. In case of an insured event according to Art. 3 paragraph 1 letters a) and b) of these SPC Smart (death of the first insured person / reaching the arranged end of insurance by the first insured person) the topical value of gained loyalty bonus (not yet invested into the Guaranteed fund) will be paid along with the benefit.
5. **If the insurance contract lapses due to another fact than due to an insured event mentioned in Art. 3 paragraphs a) and b) of these SPC Smart or the insurance is transferred into repaid status, the value of gained loyalty bonus (not yet invested into the Guaranteed fund) lapses without compensation as of this date.**
6. **The policyholder acknowledges that he/she arranges a linearly decreasing sum assured at a rider in the insurance contract, the sum assured will gradually automatically decrease at the rider up to the level of the minimum sum assured set for this case in the tariff of charges in compliance with the relevant insurance conditions for such rider, which will lead to a decrease in premium for this rider and can also lead to the result during the insurance contract duration that the condition for acknowledgment of the loyalty bonus will not be met from a certain moment according to paragraph 1 letter b) of this Article.**

Article 6 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract.
2. The policyholder is entitled to pay additional premium anytime during the insurance duration. However, the level of such additional premium must not be lower than the minimum level of additional premium set by the insurance company in the overview of charges. The insurance company reserves the right to set also the maximum level of additional premium in the overview of charges, which the policyholder is also obliged to keep at payment of additional premium.
3. At payments of regular premium in the way described in Art. 17 (interruption of obligation to pay regular premium) and Art. 18 (transfer of insurance into repaid status) of these SPC Smart, such paid premium will not be taken into consideration at preparation of the insurance company's confirmation about premium that was paid for life insurance during the previous taxation period according to the relevant legal regulations.

Article7 - In which way is risk premium charged and how is its level set?

1. Risk premium is charged monthly and paid in the same way as the management charge for administrative costs according to Art. 9 of these SPC Smart. Risk premium is charged separately for the first insured person and separately for the second insured person. If the insured person is younger than 3 years, risk premium is charged only from the first month following after reaching the age of 3 years.
2. The level of risk premium for the first insured person is equal to a multiple of the premium rate, which is set in the tariff of charges for each insurance year for the topical age of the first insured person, and the amount, by which the unit account's value is lower than the sum assured for case of the first insured person's death as of the date of risk premium maturity. The level of risk premium for the second insured person is equal to a multiple of the sum assured for case of the second insured person's death and the premium rate, which is set in the tariff of charges for the whole period of insurance duration according to the length of the arranged duration of cover and the age of the second insured person as of the insurance start. Risk premium maturity is equal to maturity of the management charge for administrative costs described in Art. 9 of these SPC Smart.

Article 8 - In which way and where is premium invested?

1. Units of financial funds will be purchased for regular premium according to the allocation ratio determined by the policyholder.
2. The policyholder is entitled to change the allocation ratio of regular premium during the insurance contract duration. Change in the allocation ratio of regular premium is subject to a charge, which will be set by the insurance company in the overview of charges.
3. Units will be purchased for regular premium after settlement of the charge to cover initial costs of the insurance company for the purchase price latest from the nearest appraisal day after fulfilment of these conditions:
   a) Paid regular premium is credited in favour of the insurance contract and
   b) The arranged day of insurance start occurred in case of regular premium for the first insurance period and all conditions for issuance of the policy by the insurance company have been met or
   c) The maturity date of regular premium occurred in case of regular premium for the following period.
4. Units of financial funds will be purchased for additional premium according to the allocation ratio set by the policyholder. When paying additional premium, the policyholder is obliged to determine by the variable symbol of payment whether it is single or repeated additional premium.
5. In case of single additional premium units will be purchased for it for the purchase price latest from the nearest appraisal day after the following conditions have been met simultaneously:
   a) Paid additional premium is credited in favour of the insurance contract,
   b) The insurance company will receive a written instruction of the policyholder about the allocation ratio of this single additional premium.

   If the policyholder does not meet the condition described under letter d) of the previous paragraph after payment of single additional premium within 30 calendar days, the insurance company will place the single additional premium into financial funds according to the allocation ratio arranged for repeated additional premium after vain expiry of this period. **If allocation ratio is not arranged for repeated additional premium, the insurance company will place the single additional premium according to the allocation ratio arranged for regular premium.** Units will be purchased for the purchase price latest from the nearest appraisal day after expiry of 30 calendar days from the day when the paid additional premium has been credited in favour of the insurance contract.
6. In case of repeated additional premium, the allocation ratio for repeated additional premium set in advance will be used that can be arranged by a proposal for change in the insurance contract. The policyholder is entitled to change such an allocation ratio arranged in advance for repeated additional premium anytime during the insurance duration. **If this allocation ratio for repeated additional premium is not arranged as of the day of repeated additional premium payment, the insurance company will place the repeated additional premium into financial funds according to the allocation ratio, which was arranged for regular premium. Units will be purchased for additional premium for the purchase price latest from the nearest appraisal day after the paid additional premium has been credited in favour of the insurance contract.**
7. The number of purchased units will be determined on the basis of the purchase price.

Article 9 - What rules are the charges governed by?

1. The amount of charges to this insurance and way of their payment are set in the overview of charges effective as of the day of the relevant act's performance, for which they are charged.
2. The management charge for administrative costs is charged monthly and paid in the form of units' deduction from the unit account's value that means the unit account's value will decrease every month by such a number of units, which correspond with the amount of this charge set in the overview of charges by its value.
3. The collection charge is charged for each payment of regular premium that means in dependence on the arranged insurance period and is paid in the form of units' deduction from the unit account's value that means the unit account's value will decrease by such a number of units along with each payment of regular premium, which correspond with the amount of the collection charge set in the overview of charges by its value.
4. In case of monthly insurance period, maturity of the management charge for administrative costs is always as of the day of regular premium maturity and in case of quarterly/semi-annual/annual insurance period

as of the relevant day of each calendar month, which accords with the anniversary day. Maturity of the collection charge is always as of the day of regular premium maturity. Maturity of other charges is as of the day of the relevant act's performance, for which they are charged.

5. It is valid for charges paid in the form of units' deduction from the unit account's value that if units are placed in various financial funds, the number of units deducted for charges is calculated pro rata from the values of units of individual financial funds. To determine the number of deducted units, the insurance company starts from the selling price valid latest from the nearest appraisal day after the maturity date of the given charge. If the value of units is not sufficient as of the given moment (see the status of so-called accumulated debt described in Art. 11 of these SPC Smart), the selling price valid latest from the nearest appraisal day after the relevant increase in the value of units will be used. The procedure described in this paragraph is similarly valid for special cases of regular premium payment and/or payment of charges from the unit account's value according to Art. 17 (interruption of the obligation to pay regular premium) and Art. 18 (transfer of insurance into repaid status) of these SPC Smart.

Article 10 - In which way is the fee for coverage of the insurance company's initial costs charged?

1. The insurance company will deduct a fee for coverage of the insurance company's initial costs from each paid regular premium for the first insured person for the period of the first 60 months from the insurance start. The level of this fee is set as so-called allocation percentage from the amount of regular premium for the main coverage, which is arranged for the first insured person for the first insurance period. The arranged duration of cover of the first insured person is decisive for determination of the allocation percentage level specified in the overview of charges, but its possible subsequent shortening does not lead to a reduction in the fee.
2. If regular premium for the Main coverage of the first insured person decreases in the mentioned period of the first 60 months, the fee is further set as a so-called allocation percentage from the topical value of regular premium for the first insured person after the decrease.
3. Similarly if there is an increase in regular premium anytime during the insurance contract duration (for main coverage of the first insured person), the insurance company will deduct a fee for coverage of the insurance company's initial costs from the amount, by which regular premium was increased, for the period of the first 60 months from such increase. The level of this fee will be set as so-called allocation percentage from the amount, by which regular premium was increased. The remaining duration of cover of the first insured person's insurance from the day of regular premium increase is decisive for determination of the level of allocation percentage specified in the overview of charges.
4. **The fee for coverage of the insurance company's initial costs is paid by a deduction from premium for the entire insurance period; in case of insurance lapse with payment of surrender during the insurance period, the fee deducted from premium paid for this insurance period is returned in the ratio to the number of the months of insurance duration in this insurance period that have not begun yet.**
5. **If the insurance is transferred into repaid status according to Art. 18 of these SPC Smart and/or if the insurance lapses before settlement of the payment for coverage of the insurance company's initial costs for all 60 months according to paragraphs 1., 2. or 3. of this Article, the fees for coverage of the insurance company's initial costs that have not been paid yet for the period from the date of the insurance transfer into repaid status and/or until the date of insurance lapse are paid as a single payment as of the topical date and this in the form of units' deduction from the value of the units' account.**

Article 11 - What is the procedure in case that the unit account's value is not sufficient to cover the charges (that means in case of so-called accumulated debt)?

1. **Accumulated debt is understood as status of the insurance contract when the unit account's value is not sufficient to cover risk premium and/or any charges paid in the form of units' deduction from the unit account's value on the day of their maturity**. In such a case the unpaid part of risk premium and/or relevant charges is transferred to another month and will be paid from units purchased for the following premium payments (regular or additional) that means after increase of the unit account's value.
2. If an insurance contract, which is valid at least 3 years, is in the status of accumulated debt, the insurance company will notify the policyholder of this fact in writing and at the same time it will call on him/her to increase the unit account's value.
3. **If an insurance contract, which is valid at least 4 years, is in the status of accumulated debt, the insurance company will set a period to the policyholder in the written notification of the accumulated debt's existence and of the necessity to increase the unit account's value that must not be shorter than 14 days and at the same time longer than 3 months from the day of the written notification's delivery to the policyholder. If the policyholder does not increase the unit account's value to a level sufficient to cover risk premium and/or the mentioned charges within the set period, the insurance contract will lapse as of the day following after expiry of the mentioned period. If the policyholder is entitled to surrender as of the moment of the insurance contract lapse, the insurance company will pay an amount corresponding with the surrender value to the policyholder after the insurance contract lapse at the same time.**

Article 12 - In which way is the value of financial fund appraised and under what conditions can a change in the funds offered for investment occur?

1. Appraisal of the financial funds' value is done at least once a week.
2. The insurance company is entitled to deduct a charge for the insurance company from the financial fund's value for mediation of the fund and for total costs of the fund, whose level is set in the overview of charges.
3. The financial funds' value is equal to the value of financial fund's assets decreased by the value of unpaid costs and by charges that are mentioned in the previous paragraph.
4. The selling price of a financial fund's unit is set as a share on the fund's value and the total number of units of this fund. The result will be rounded by 1 % at the most.
5. The purchase price of a financial fund's unit is set in such a way that the difference between the purchase and selling prices correspond with the percentage level set in the overview of charges.
6. The insurance company has the right to include a new financial fund in its offer.
7. **The insurance company has the right to completely cancel and/or exclude some financial fund from its offer for future investment of the policyholder if there is a reasonable need for change (especially in connection with development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development, due to a material change in market conditions or at change of currency, in which the fund was maintained).**
   a) In case of a financial fund's cancellation, the insurance company will deliver a written notification of the financial fund's cancellation date to the policyholder at least on the 45th calendar day before cancellation of the financial fund. Also a proposal for new allocation ratio for possible future investments of the policyholder (premium payment) and free transfer of the policyholder's units from this fund to other financial funds offered by the insurance company will be a part of this notification. If the policyholder does not agree with such a proposal of the insurance company, he/she is obliged to deliver a written request to the insurance company latest on the 30th calendar day before cancellation of the financial fund where he/she determines the new placement of units and the new allocation ratio himself/herself. If the policyholder does not do so and he/she also does not use his/her right to cancel the insurance contract due to disagreement in such a way as it is described below under letter c) of this paragraph, the transfer of units and change in the allocation ratio will be realised according to the mentioned proposal of the insurance company.
   b) In case of a financial fund's exclusion, the insurance company will deliver a written notification about the date of the financial fund's exclusion to the policyholder at least on the 45th calendar day before exclusion of the relevant financial fund. Also a proposal for new allocation ratio for future investments of the policyholder (premium payment) will be a part of the insurance company's notification; the existing units of the policyholder in this excluded fund will remain unaffected. If the policyholder does not agree with such a proposal of the insurance company, he/she is obliged to deliver a written request to the insurance company latest on the 30th calendar day before exclusion of the financial fund with his/her own determination of the new allocation ratio. If the policyholder does not do so and he/she also does not use his/her right to cancel the insurance contract due to disagreement in such a way as it is described below under letter c) of this paragraph, units will be

purchased for paid premium according to the allocation ratio mentioned in the insurance company's proposal in question.

c) **The policyholder has the right to deny the proposal of the insurance company according to letters a) or b) of this paragraph and at the same time to cancel the insurance contract due to disagreement with the proposed change, however, this only under the condition that he/she will deliver a written notice to the insurance company latest on the 30th calendar day before cancellation or exclusion of the financial fund. The notice period, by whose expiry the insurance contract lapses, represents 20 calendar days from the day of the notice delivery in this case. If the policyholder is entitled to surrender as of the moment of the insurance contract lapse, the insurance company will pay an amount corresponding to the surrender value to the policyholder after the insurance contract lapse at the same time.**

8. In case of cancellation or exclusion of the Guaranteed Fund from offer of the insurance company, insurance company will replace it by a new Guaranteed fund.

Article 13 - In which way is the fee for coverage of the insurance company's initial costs charged?

1. The policyholder is entitled to carry out one transfer of units among the financial funds and/or from the financial funds into the Guaranteed fund in each insurance year free of charge. Every other transfer of units realised in the same insurance year is subject to a charge that is set by the insurance company in the overview of charges. Transfer of units from the Guaranteed fund into financial funds and further on transfer of units already invested according to NN life cycle strategy is absolutely excluded.
2. The policyholder's request for transfer of units must be in writing and becomes effective on the nearest following working day after the day of its delivery to the insurance company or optionally on another later working day mentioned in this request. If the policyholder mentions a later date in the request, the transfer will be realised in a similar way as of the requested date.
3. The selling price latest from the nearest appraisal day after the effective day of the request for transfer of units will be used for transfer of units among the financial funds.

Article 14 - How can I withdraw a part of invested funds during insurance duration?

1. The policyholder has the right to ask for an extraordinary withdrawal of a part of the financial account's value in writing anytime **only if he/she selected in the insurance contract, by proposal for its change or by another written submission that his/her insurance contract should not be subject to tax relief.**
2. The insurance company is entitled to set minimum and maximum levels for extraordinary withdrawals from individual financial funds. The insurance company is entitled to charge a fee for payment of extraordinary withdrawal of units set by the insurance company in the overview of charges.
3. The request for extraordinary withdrawal becomes effective on the nearest following working day after the delivery day to the insurance company or optionally on another later working day mentioned in this request. If the policyholder mentions a later date in the request than the delivery day of the request to the insurance company, the extraordinary withdrawal will be realised in a similar way as of the requested date.
4. By realisation of the request for extraordinary withdrawal the status of unit account will change in such a way that the number of units corresponding with the requested value of extraordinary withdrawal will be deducted from it. The insurance company starts from the selling price valid latest on the nearest appraisal day after the effective day of the request for extraordinary withdrawal at determination of the number of deducted units.
5. The insurance company will pay the value of extraordinary withdrawal to the policyholder latest within a month from the effective day of the request for extraordinary withdrawal.
6. The insurance company has the right to decrease the sum assured set in the insurance contract as of the effective date of the request for extraordinary withdrawal, however, by the requested value of the extraordinary withdrawal at the most. It will inform the policyholder about this decrease in writing.

Article 15 - What period do I arrange the insurance for?

The insurance is arranged for the duration of cover mentioned in the insurance contract, which starts by the day mentioned in the insurance contract as the insurance start and terminates by expiry of the duration of cover. The insurance also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this insurance that is mentioned in the insurance contract and this as of the day of the main coverage anniversary.

Article 16 - What is necessary to know generally about some changes in insurance?

1. If the policyholder asks for an increase in the sum assured, which does not exceed the maximum sum assured mentioned in the tariff of charges (under the condition that the insurance company will set such a value), the insurance company will carry out the change while keeping the original amount of regular premium (only risk premium paid from units will increase). If the proposed increase in the sum assured exceeds the maximum sum assured mentioned in the tariff of charges (under the condition that the insurance company will set such a value), the insurance company will ask for a corresponding/adequate increase in regular premium. The insurance company will notify the policyholder of this fact without an unnecessary delay. In case of the policyholder's request for an increase in the sum assured, the insurance company is also entitled to ask for topical information about the health status of the insured person.
2. If the policyholder asks for a decrease in the sum assured, the requested sum assured must not be lower than the minimum sum assured mentioned in the tariff of charges (under the condition that the insurance company will set such a value).
3. If the policyholder asks for an increase in regular premium, the amount of regular premium must not be higher than maximum regular premium mentioned in the tariff of charges (under the condition that the insurance company will set such a value).
4. If the policyholder asks for a decrease in regular premium, the requested amount of regular premium must not be lower than minimum regular premium mentioned in the tariff of charges (under the condition that the insurance company will set such a value). In connection with this the insurance company reserves the right to carry out a corresponding/adequate decrease in the sum assured in case that in relation to the decreased regular premium the arranged sum assured does not correspond with the coefficient of maximum sum assured in relation to the premium level and to the age of the insured person (under the condition that the insurance will set this coefficient in the tariff of charges). The insurance company will notify the policyholder of this fact without an unnecessary delay. If there is a decrease in regular premium to an amount, which is not sufficient to cover risk premium and/or charges paid in the form of units' deduction from the unit account's value (status designated as so-called accumulated debt), the procedure according to Art. 11 of these SPC Smart will be applied.
5. If there is a concurrence of the policyholder's request for change in the insurance contract, which influences the unit account's value, with regular operations, which are performed at the unit's account in connection with the insurance (e.g. payment of charges), the insurance company will give priority to these regular operations.
6. Changes in insurance can be done only while keeping the condition for minimum scope of this insurance according to Art. 2 of these SPC Smart.

Article 17 - What period do I arrange the insurance for?

1. The policyholder has the right to ask for interruption of the obligation to pay regular premium for up to 12 calendar months following one after another in writing under the condition that the following conditions have been met as of the day of the nearest regular premium maturity following after delivery of the policyholder's request to the insurance company:

   a) Regular premium has been properly paid i.e. no debt is recorded at the insurance contract, and

   b) The value of the units' account is higher than or equal to the 1.1 multiple of the sum of anticipated fees for coverage of the insurance company's initial costs, administrative fees for administrative costs, risk premium and premium for all arranged riders, which the insurance company is entitled to for the period of interruption of the obligation to pay regular premium including the fee for interruption of the obligation to pay regular premium according to the Overview of charges.
2. **The policyholder's obligation to pay regular premium will be interrupted from the nearest maturity day of regular premium after the**

receipt of his/her request by the insurance company. The insurance company is entitled to charge a fee for interruption of the obligation to pay regular premium set in the overview of charges. The policyholder is entitled to ask for interruption of the obligation to pay regular premium according to this Article also repeatedly during the insurance contract duration.

3. **The arranged insurance coverage of the first and second insured persons is kept in the same scope during the period when the obligation to pay regular premium is interrupted, in which it was before interruption of the obligation to pay regular premium (i.e. including arranged riders). The policyholder is not entitled to change the amount of the sum assured at the main coverage or at the riders during the period of interruption of the obligation to pay regular premium. He/she is also not entitled to extend insurance coverage, i.e. to arrange further riders**.
4. **The insurance company will carry out the payment of the amounts for risk premium, premium for riders, charges for coverage of the insurance company's initial costs, collection charges and management charges for administrative costs by a decrease in the number of units in the financial funds during the period of interruption of the obligation to pay regular premium**.
5. The obligation to pay regular premium is renewed by
   a) payment of regular premium before the arranged date of the end of the period when the obligation to pay regular premium was interrupted or
   b) expiry of the arranged duration period of interruption of the obligation to pay regular premium or
   c) full consumption of all units at the unit account.
6. The policyholder will be informed about renewal of the obligation to pay regular premium in writing.

Article 18 - What does insurance in repaid status mean and under which conditions is it possible to transfer insurance into repaid status?

1. Insurance in repaid status is insurance with zero sum assured at the main coverage without obligation to pay premium. **With effect from the day of insurance transfer into repaid status the sum assured for case of the first insured person's death changes to 0 CZK, insurance coverage of the second insured person lapses, arranged riders cease and the obligation to pay regular premium expires (that means risk premium is not charged). If the insured person dies after transfer of the insurance into repaid status, the insurance company will pay the benefit to the beneficiary only on the level of the unit account's value in the status as of the day of the insured event's rise.** Insurance can be transferred into repaid status after fulfilment of the below-mentioned conditions and this either on the basis of the policyholder's request or also unilaterally by the insurance company.
2. **The policyholder has the right to ask for transfer of insurance into repaid status after payment of regular premium at least for the first 3 insurance years in writing, however, after expiry of also the third insurance year at the earliest. The insurance company is entitled to transfer insurance into repaid status after fulfilment of the conditions described below in Art. 19 paragraph 3 of these SPC Smart**.
3. The insurance company is entitled to set a minimum value of the unit account for realisation of the insurance transfer into repaid status. If the value of the unit account is not sufficient, the insurance will not be transferred into repaid status.
4. **The value of the units' account will be decreased at insurance transfer into repaid status by so far unpaid fees for coverage of the insurance company's initial costs according to Art. 10 of these SPC Smart for the period until the date of insurance transfer into repaid status. The administrative fee for administrative costs continues to be charged for the period when the insurance is in repaid status; the collection fee is not charged during this period.**
5. The policyholder is entitled to pay additional premium any time after the transfer of insurance into repaid status. **The right to extraordinary withdrawal of a part of the unit account's value lapses after the transfer of insurance into repaid status.**
6. If the unit account's value after the transfer of insurance into repaid status is not sufficient to cover any charged fees, the insurance company will notify the policyholder of this fact in writing and call on him/her to increase the unit account's value. If the policyholder does not increase the unit account's value by payment of additional premium, the insurance will lapse as of the day of full consumption of all units at the unit account (that means without compensation).

Article 19 - What happens if I stop paying premium?

1. If the policyholder owes regular premium for certain insurance periods and the **unit account's value is not sufficient to cover the outstanding risk premium, charges for coverage of the insurance company's initial costs and/or any charges paid in the form of units' deduction from the unit account's value, the insurance lapses without compensation due to non-payment of premium,** and this by vain expiry of the period for payment of outstanding premium set by the insurance company in the reminder sent to the policyholder.
2. If the policyholder owes regular premium for certain insurance periods and **after deduction of the outstanding risk premium, charges for coverage of the insurance company's initial costs and/or any charges paid in the form of units' deduction from the unit account's value**, **the unit account's value does not achieve the minimum value for transfer of insurance into repaid status set by the insurance company in the overview of charges, the insurance lapses due to non-payment of premium by vain expiry of the period for payment of outstanding premium** set by the insurance company in the reminder sent to the policyholder. **The insurance company will pay the amount corresponding with the surrender value to the policyholder after the insurance lapse.**
3. If the policyholder owes regular premium for certain insurance periods and **after deduction of the outstanding risk premium, charges for coverage of the insurance company's initial costs and/or any charges paid in the form of units' deduction from the unit account's value**, **the value of units achieves the minimum value for transfer of units into repaid status set by the insurance company in the overview of charges,** in compliance with Art. 18 of these SPC Smart the insurance company **will transfer the insurance into repaid status** as of the day of vain expiry of the period for payment of outstanding premium set by the insurance company in the reminder sent to the policyholder.
4. The selling price latest from the nearest appraisal day after vain expiry of the period for payment of outstanding premium set by the insurance company in the reminder sent to the policyholder will be used for determination of the unit account's value.

Article 20 - Under which conditions can I ask for insurance termination with payment of surrender and how is its amount set?

1. The policyholder has the right to termination of insurance with payment of surrender on the basis of his/her written request after the first month of the insurance duration.
2. The request for insurance termination with payment of surrender becomes effective on the nearest working day after its delivery to the insurance company or on another later working day mentioned in this request (unless the day specified in the application business day).
3. The surrender value is equal to the unit account's value to the effective date of the request for termination of insurance with the surrender payment after deducting fees to cover the initial costs of insurance, unearned premiums and unpaid fees paid by deducting units. To determine the value of the investment account will be used later than the selling price of the next valuation day after the effective date of the application for termination of insurance with the surrender payment.

Article 21 - When are these special insurance conditions effective from?

These insurance conditions become effective on October 1, 2016.

Article 22 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Allocation ratio
Ratio, in which paid premium is placed into selected financial funds.

The second insured person
Natural person, to whose life, health or bodily injury, this insurance type relates and that is insured along with the first insured person by the same insurance contract.

Financial fund(s)
Internal fund of the insurance company representing the portfolio of various investment types, which are administered by the insurance company or by its agent exclusively for the purposes of life insurance; their more detailed specification is mentioned in Key Information.

Guaranteed fund
Financial fund where non-negative development of the unit's price and possible appreciation on the level mentioned in the notification at the website www.nn.cz are guaranteed. The insurance company is entitled to change the level of appreciation anytime. Present appreciation of units is not affected by a change in the level of appreciation for further periods.

Value of the units' account
Summary of the financial funds values determined as a product of the number of individual financial funds' units and their selling prices.

Purchase price
Price, for which a unit may be purchased, calculated by the insurance company according to the conditions mentioned in Art. 12 of these SPC Smart.

Appraisal day
Working day, as of which the insurance company calculates the purchase and selling prices of units of individual financial funds.

Start of insurance
Start of insurance of the first insured person unless it is explicitly mentioned in these SPC Smart that it is start of insurance of the second insured person.

Unit
Share on the property of the financial fund, which represents a claim to a part of this fund's value.

Unit account
Individual account maintained by the insurance company to the insurance contract, which is created by units of financial funds.

Sum assured
Sum assured that is arranged for case of the first insured person's death in the insurance contract unless it is explicitly mentioned in these SPC Smart that it is the sum assured for case of the second insured person's death.

Selling price
Price, for which a unit may be sold, calculated by the insurance company according to the conditions mentioned in Art. 12 of these SPC Smart.

First insured person
Natural person, to whose life, health or bodily injury this type of insurance relates and that is insured either independently or together with the second insured person on the insurance contract.

Table of natural rates UZ3C

Age	0-3	4-18	19	20	21	22	23	24-25	26	27	28	29	30	31	32	33
Rate (in CZK)	0.01	5.57	6.37	6.76	6.49	6.54	6.47	6.72	6.59	6.55	6.60	6.85	7.09	7.43	7.86	8.46
Age	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Rate (in CZK)	9.03	10.01	10.49	12.17	13.65	15.04	16.32	17.83	19.75	21.51	24.19	27.06	30.75	35.04	39.93	44.12
Age	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
Rate (in CZK)	48.66	53.73	59.35	66.12	73.57	80.46	87.70	96.41	105.15	116.19	128.31	139.88	151.86	163.75	174.89	188.80
Age	66	67	68	69	70	71	72	73	74	75						
Rate (in CZK)	204.96	222.70	242.39	263.90	287.18	314.58	346.54	381.48	420.31	466.13						

Special insurance conditions for insurance of the type
RIDER AGAINST DEATH RESULTING FROM ACCIDENT OR DISEASE CSO3
RIDER AGAINST DEATH RESULTING FROM ACCIDENT OR DISEASE CSO6

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider against death resulting from accident or disease CSO3 and rider against death resulting from accident or disease CSO6 (hereinafter only "SPC CSO3/CSO6") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CSO3/CSO6 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CSO3/CSO6.
3. This rider may be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme are mentioned in GTC, then they do not relate to the rider CSO6. If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they neither relate to the rider CSO3 nor to the rider CSO6.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **Death as a result of an accident or disease of the insured person is considered as an insured event within this rider.**
2. In case of an insured event, the insurance company will pay the benefit on the level of the sum assured valid as of the day of the insured event's rise to the beneficiary.
3. **An insured event is reported to the seat of the insurance company without an unnecessary delay, and this on the prescribed "Claim notification" form of the insurance company**, which is available at the websites of the insurance company or in the environment of the insurance company's service portal.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. In case of the rider CSO3, the amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the whole duration of cover in dependence on the age of the insured person as of the rider's start and on the arranged duration of cover; therefore fixed premium rates are arranged for this rider.In case of the rider CSO6, the amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the topical age of the insured person and the topical insurance year. Therefore premium rates increasing with passing time are arranged for this rider (so-called natural premium) whereas particular amount of regular premium for the first insurance year is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and particular amount of regular premium for each following insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written notification to the policyholder 8 weeks before the main coverage anniversary at the latest.

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the duration of cover mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

The right to benefit payment does not arise if disability occurred in direct or indirect connection with:

a) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

b) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

c) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally), and this as of the anniversary day of the main coverage.
3. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider with the purpose to determine insurance risk and the level of premium. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
3. If a period is set for a certain act in these SPC CSO3/CSO6 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CSO3/CSO6 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CSO3/CSO6 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CSO3/CSO6 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CSO3/CSO6 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period

represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CSO3/CSO6 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Tariff of charges

Tariff of charges of the insurance company containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual types of the main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of the rider' duration and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Table of natural rates CSO6

Age	15	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55
Rate (in CZK)	5.57	5.97	6.59	6.74	8.56	13.62	22.07	39.7	66.65
Age	56-60	61-65	66-70	71-75					
Rate (in CZK)	106.75	163.84	244.23	385.81					

Special insurance conditions for insurance of the type
RIDER AGAINST DEATH RESULTING FROM ACCIDENT OR DISEASE CSO4
RIDER AGAINST DEATH RESULTING FROM ACCIDENT OR DISEASE CSO5

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider against death resulting from accident or disease CSO4 and rider against death resulting from accident or disease CSO5 (hereinafter only "SPC CSO4/CSO5") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CSO4/CSO5 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CSO4/CSO5.
3. This rider may be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **Death as a result of an accident or disease of the insured person is considered as an insured event within this rider.**
2. In case of an insured event, the insurance company will pay the benefit on the level of the sum assured valid as of the day of the insured event's rise to the beneficiary.
3. The sum assured is linearly decreasing that means it is decreased by 1/n of the arranged sum assured as of each anniversary day where "n" represents the arranged duration of cover in years. If there is a change in this rider on the basis of a policyholder's request (change in the sum assured or in the duration of cover), the sum assured is decreased by 1/n of the newly arranged sum assured as of each anniversary where "n" represents the newly arranged duration of cover rounded to whole years upwards, rounded to whole thousands of Czech crowns upwards. In case of the rider CSO4, a sum assured decreasing according to a payment schedule may be arranged instead of a linearly decreasing sum assured when the sum assured is decreasing as of selected anniversaries to sums set by the policyholder.
4. **An insured event is reported to the seat of the insurance company without an unnecessary delay, and this on the prescribed "Claim notification" form of the insurance company**, which is available at the websites of the insurance company or in the environment of the insurance company's service portal.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. In case of the rider CSO4, the amount of regular premium is equal to a multiple of the topical sum assured for this rider and the premium rate set in the tariff of charges for the topical age of the insured person and the topical insurance year. Therefore premium rates increasing with passing time are arranged for this rider (so-called natural premium) whereas particular amount of regular premium for the first insurance year is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and particular amount of regular premium for each following insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written notification to the policyholder 8 weeks before the main coverage anniversary at the latest.
3. In case of the rider CSO5, the amount of regular premium is the same for the whole period of the rider's duration and is equal to a multiple of the sum assured topically valid as of this rider's start and the premium rate set in the tariff of charges for the whole duration of cover in dependence on the age of the insured person as of the rider's start and on the arranged duration of cover; therefore fixed premium rates are arranged for this rider. Only 1 % of premium set according to the previous sentence is paid during the last 3 years of the rider's duration.

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the duration of cover mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

The right to benefit payment does not arise if disability occurred in direct or indirect connection with:

a) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

b) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

c) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally), and this as of the anniversary day of the main coverage aniversary.
3. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. If the possibility to arrange a linearly decreasing sum assured or a sum assured decreasing according to a payment schedule is mentioned in the insurance contract in relation to this rider, the policyholder has the right to arrange any of these options also during the rider's duration by a proposal for change in the insurance contract.
2. In case of the rider CSO5, it is not possible to contractually change the level of the sum assured or to shorten the duration of cover during the last 5 years of the rider's duration, then it is also not possible to prolong the duration of cover during the last 3 years of this rider's duration.
3. The insurance company examines the health status of the insured person at the arrangement of this rider with the purpose to determine insurance risk and the level of premium. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
4. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the**

insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.

5. If a period is set for a certain act in these SPC CSO4/CSO5 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
6. **The insurance company has the right to perform an adequate change in these SPC CSO4/CSO5 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CSO4/CSO5 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CSO4/CSO5 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CSO4/CSO5 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CSO4/CSO5 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Tariff of charges

Tariff of charges of the insurance company containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual types of the main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of the rider' duration and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Table of natural rates CSO4

Age	0-3	4-18	19	20	21	22	23	24-25	26	27	28	29	30	31	32	33
Rate (in CZK)	0.01	5.57	6.37	6.76	6.49	6.54	6.47	6.72	6.59	6.55	6.60	6.85	7.09	7.43	7.86	8.46
Age	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Rate (in CZK)	9.03	10.01	10.49	12.17	13.65	15.04	16.32	17.83	19.75	21.51	24.19	27.06	30.75	35.04	39.93	44.12
Age	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
Rate (in CZK)	48.66	53.73	59.35	66.12	73.57	80.46	87.70	96.41	105.15	116.19	128.31	139.88	151.86	163.75	174.89	188.80
Age	66	67	68	69	70	71	72	73	74	75						
Rate (in CZK)	204.96	222.70	242.39	263.90	287.18	314.58	346.54	381.48	420.31	466.13						

Special insurance conditions for insurance of the type RIDER FOR CASE OF DEATH DUE TO ACCIDENT 0012

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of death due to an accident 0012 (hereinafter only "SPC 0012") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC 0012 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC 0012.
3. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider**.

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event within this rider is death of the insured person due to an accident under the condition that the death occurred within 3 years since the accident.**
2. In case of an insured event the insurance company will pay the benefit to the beneficiary in the amount of the sum assured valid as of the day of the insured event's rise.
3. In addition the insurance company will pay to the beneficiary a bonus on the level of 100 % of the sum assured valid as of the day of the insured event's rise along with the benefit if the injury, due to which the insured person died, happened at a traffic accident of a car, a bus, a train, a ship, at an air crash, a public transport accident, a bicycle or a motorbike accident and at the time of the traffic accident the insured person was in/on board of the mentioned means of transport participating in the traffic accident or he/she participated in the traffic accident only as a pedestrian. For the purposes of this rider traffic accident is understood as an incidental event directly connected with operation of the mentioned means of transport, at which the insured person is injured or killed. The claim to bonus does not arise in case that the insured person caused the traffic accident by his/her behaviour.
4. **If this rider is arranged along with the rider of permanent consequences of accident, then should the insured person die due to the consequences of the accident after the date when the insurance company has already provided benefit payment for permanent consequences of this accident, the benefit to this rider is determined as the difference between the arranged sum assured to this rider and the amount, which has already been paid for permanent consequences of the accident**.
5. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self-service portal.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges.

Article 4 – For which period do I arrange the rider?

1. The rider is arranged for the duration of cover mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

The right to benefit payment does not arise if the death due to an accident occurred in direct or indirect connection with:

a) Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
b) Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;
c) Mental disorder of the insured person;
d) Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;
e) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;
f) Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;
g) Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;
h) Professional operation of a sport by the insured person;
i) Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;
j) Accident of the insured person caused in connection with any of his/her diseases including worsening of the disease;
k) Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);
l) Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
3. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
2. If a period is set for a certain act in these SPC 0012 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
3. **The insurance company has the right to perform an adequate change in these SPC 0012 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's**

approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC 0012 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company. The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC 0012 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC 0012 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC 0012 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER FOR CASE OF PERMANENT CONSEQUENCES OF ACCIDENT WITH PROGRESSIVE BENEFIT 0314

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for case of permanent consequences of accident with progressive benefit 0314 (hereinafter only "SPC 0314") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC 0314 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC 0314.
3. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider**.

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event and what is understood by "progressive benefit"?

1. **An insured event within this rider are permanent consequences of an accident mentioned in the Supplement to these SPC 0314 and these permanent consequences are diagnosed by the relevant doctor within 3 years since the accident.** Permanent consequences of accident mean physical or functional bodily injury, which is declared as permanent status after termination of the treatment by the relevant doctor.
2. In case of an insured event the insurance company will pay the **benefit** to the beneficiary **in the amount of the relevant percentage from the sum assured valid as of the day of the insured event's rise multiplied by the progression coefficient according to the below-mentioned chart.** This percentage for calculation of benefit payment is set in dependence on the scope and nature of bodily injury assessed by the relevant specialist doctor of the insurance company on the basis of submitted medical records of the insured person, however, always only up to the maximum percentage of the benefit mentioned for individual types of permanent consequences in the Supplement to these SPC 0314.

Set percentage from the sum assured for individual types of permanent consequences	Progression coefficient
1–25 % including	1
26–50 % including	2
51–75 % including	3
76–99 % including	4
100 %	6

3. In case that more organs or parts of the body are injured by a single accident, the relevant percentage from the sum assured (maximum % of benefit) mentioned for individual types of permanent consequences in the Supplement to these SPC 0314 are added up. **Benefit payment can be set on the maximum level of 100 % of the sum assured due to a single insured event (before multiplication by progression coefficient).**
4. **If the after-effect of a single accident is a multiple injury of a single organ, extremity or part of the body, the benefit for this handicap will be determined by the insurance company according to the highest suffered level of disablement of the given organ, extremity or part of the body that means not by summary of the percentages from the sum assured corresponding with all individual injuries of the same organ, extremity or part of the body of the insured person**.
5. In case of a partial loss of an organ or a partial loss of its function the level of benefit payment will be derived from the benefit for complete loss of organ or complete loss of its function. **In case of permanent consequences of the accident, which are not explicitly mentioned in the Supplement to these conditions, the insurance company will determine the benefit level on the basis of a medical comparison of their severity with the consequences mentioned therein.**
6. **If the accident results in an injury of such a bodily part, which was handicapped/injured already before the start of this rider, the assessment of these consequences will be decreased proportionally in such a way that it corresponds with the real consequences of the given accident**. The insurance company will use percentages from the sum assured mentioned in the Supplement to these SPC 0314 for assessment of injury that existed already before the start of this rider.
7. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. If the insured person is not able to report the insured event to the insurance company himself/herself with regard to the severity of his/her health status and he/she will even not be able to ask for benefit payment, also the policyholder, a person close to the insured one or sharing a common household with him/her or also another person that has a legal interest in benefit payment is entitled to report the insured event. In such a case the benefit will be paid in favour of the bank account arranged in the insurance contract for these purposes unless the insured person sets otherwise within examination of the insured event.
8. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

The right to benefit payment does not arise if the permanent consequences of accident occurred in direct or indirect connection with:

a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**

b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**

c) **Mental disorder of the insured person;**

d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**

e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**

f) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**

g) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**

h) **Professional operation of a sport by the insured person;**

i) **Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;**

j) **Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**

k) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**

l) **Accident of the insured person arisen at operation of sports by the**

insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data or circumstances that have an influence on insurance risk, benefit payment or existence of insurance interest (e.g. change in working, business, sport or other interest activities, change in the health status, decision concerning disability and disability pension, acknowledgement of old age pension and the like).**
2. **The insurance company has the right to adequately decrease premium payment in cases when the policyholder or the insured person did not inform the insurance company about a change in his/her profession or registered sports activity, which would mean inclusion of the insured person into a higher risk group.**
3. If a period is set for a certain act in these SPC 0314 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC 0314 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC 0314 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC 0314 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC 0314 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC 0314 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also another profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF RIDER 0314

Definition of terms for purposes of benefit payment determination:

1. Restricted mobility compared to the healthy side or compared to common scope of mobility by 10.1 % to 25 % is understood as light level of restricted mobility.
2. Restricted mobility compared to the healthy side or compared to common scope of mobility by 25.1 % to 50 % is understood as middle level of restricted mobility.
3. Restricted mobility compared to the healthy side or compared to common scope of mobility by more than 50 % is considered as high level of restricted mobility.

Permanent consequences:	Maximum % of benefit:
1) Head and sensory organ injuries	
001 Complete cranial vault defect in the extent to 2 cm^2	5 %
002 Complete cranial vault defect in the extent to 5 cm^2	10 %

003 Complete cranial vault defect in the extent to 10 cm^2	15 %
004 Complete cranial vault defect above 10 cm^2	25 %
005 Mild objective symptoms or subjective complaints found through medical observation without objective findings after severe head injuries	20 %
006 Severe neurological brain disturbances after severe head injury according to degree	100 %
007 Subjective complaints after severe injuries to other bodily parts without objective findings as found through medical observation	15 %
008 Loss of jaws	60 %
009 Restricted mobility of the lower jaw (with partial mouth opening to 1 cm)	5 %
010 Complete loss of mobility of the lower jaw	25 %
011 Traumatic disturbance of the facial nerve, mild degree	10 %
012 Traumatic disturbance of the facial nerve, severe degree	15 %
013 Traumatic damage to the trigeminal nerve according to degree	15 %
014 Facial damage accompanied by functional disturbances or arousing feelings of compassion or loathing, mild degree	10 %
015 Facial damage accompanied by functional disturbances or arousing feelings of compassion or loathing, moderate degree	20 %
016 Facial damage accompanied by functional disturbances or arousing feeling of compassion or loathing, severe degree	35 %
017 Cerebral fistula after skull base injury (liquorrhea)	15 %
018 Nasal deformation with functional disturbance of patency	10 %
019 Total loss of nose without stenosis	15 %
020 Total loss of nose with stenosis	25 %
021 Loss of nasal tip	8 %
022 Chronic atrophic mucous membrane inflammation after burn (chemical) or burn	10 %
023 Nasal septum perforation	5 %
024 Chronic purulent posttraumatic sinusitis	10 %
025 Loss of smell	10 %
026 Loss of taste	5 %
027a Reduced visual acuity in one eye – vague and blurred vision	10 %
027b **Reduced visual acuity in one eye – keeping of outlines, distinction of light** and darkness	25 %
027c Total loss of vision in one eye	50 %
028a Reduced visual acuity in both eyes - vague and blurred vision	20 %
028b **Reduced visual acuity in both eyes – keeping of outlines, distinction of light** and darkness	50 %
028c Total loss of vision in both eyes	100 %
029 Loss of vision, for each anatomical loss of an eye addition of	5 %
030 Concentric and non-concentric narrowing of the visual field	20 %
031 Loss of the crystalline lens in one eye, including accommodation disturbance below 25 years of age	15 %
032 Loss of the crystalline lens in one eye, including accommodation disturbance below 35 years of age	10 %
033 Loss of the crystalline lens in one eye, including accommodation disturbance above 35 years of age	5 %
034 Traumatic disturbance of oculomotor nerves or equilibrium disturbance of oculomotor muscles	25 %
035 Disturbed patency of the lacrimal duct in one eye	5 %
036 Disturbed of patency of the lacrimal ducts in both eyes	10 %
037 Wrong position of the eyelashes not correctable with surgery on one eye	5 %
038 Wrong position of the eyelashes not correctable with surgery on both eyes	10 %
039 Ptosis of the upper lid not correctable with surgery, one-sided	15 %
040 Ptosis of the upper lid not correctable with surgery, bilateral	60 %
041 Traumatic disturbance of accommodation, one-sided	5 %
042 Traumatic disturbance of accommodation, bilateral	8 %
043 Posttraumatic lagophthalmos not correctable with surgery, one-sided	10 %
044 Posttraumatic lagophthalmos not correctable with surgery, bilateral	15 %
045 Dilated pupil (mydriasis) and paralysis (in an eye with preserved vision) according to degree	5 %
046 Loss of one auricle	10 %
047 Loss of both auricles	15 %
048 Hardness of hearing, one-sided, moderate degree	5 %
049 Hardness of hearing, one-sided, severe degree	12 %
050 Hardness of hearing, bilateral, mild degree	10 %
051 Hardness of hearing, bilateral, moderate degree	20 %
052 Hardness of hearing, bilateral, severe degree	35 %
053 Deafness in one ear	35 %
054 Deafness in both ears	45 %
055 Labyrinthine disturbance, one-sided, according to degree	10 %
056 Labyrinthine disturbance, bilateral, according to degree	30 %
057 Permanent post-traumatic tympanic membrane perforation without manifest secondary infection	5 %
058 Chronic purulent otitis media demonstrated to be directly caused by injury	15 %
059 Complete loss of tongue	40 %
060 Loss of more than one half of the tongue	10 %
061 States after tongue injury with tissue defect or cicatricial deformations (only if loss of voice has not been judged already)	15 %
Deforming scars in the facial part of the head:	
062 lip defects	5 %
063 elongated keloid scars from 2 cm to 4 cm	2 %
064 elongated keloid scars above 4 cm	4 %
065 elongated scars from 2 cm to 4 cm	1 %
066 elongated scars above 4 cm	2 %
2) Damage to dentition (caused by injury)	
067 Loss of one tooth	1 %
068 Loss of each subsequent tooth	1 %
3) Neck injuries	
069 Stenosis of larynx or trachea, mild degree	15 %
070 Stenosis of larynx or trachea, moderate degree	30 %
071 Stenosis of larynx or trachea, severe degree	60 %
072 Loss of voice (aphonia)	20 %
073 Aggravated speech as a result of damage to the vocal apparatus or voice disturbance as a result of insufficient vocal cords	20 %
074 Loss of speech as a result of damage to the vocal apparatus	25 %
075 Status post tracheal or laryngeal injury with permanently inserted cannula	35 %
076 Status post tracheotomy with permanently inserted cannula (cannot be judged concurrently with stenosis of larynx and aphonia)	50 %
4) Thoracic, pulmonary, cardiac or oesophageal injuries	
077 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), mild degree	10 %
078 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), moderate degree	20 %
079 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), severe degree	30 %
080 Other consequences of lung injury according to degree and extent, one-sided (spirometry investigation)	40 %
081 Other consequences of lung injury according to degree and extent, bilateral (spirometry investigation)	80 %
082 Loss of one lung	35 %
083 Restricted pulmonary function from 10%	5 %
084 Restricted pulmonary function from 25 %	15 %
085 Restricted pulmonary function from 50 %	25 %
086 Restricted pulmonary function from 75%	40 %
087 Complete loss of one breast (in women)	15 %
088 Complete loss of both breasts (in women)	30 %
089 Cardiac disturbance (only after direct injury, clinically verified, according to degree, ECG investigation)	80 %

090 Oesophageal fistula	30 %
091 Post-traumatic oesophageal stenosis, mild degree	10 %
092 Post-traumatic oesophageal stenosis, moderate degree	30 %
093 Post-traumatic oesophageal stenosis, severe degree	60 %
5) Injuries affecting abdomen, digestive organs, urinary tract and genital organs	
094 Disruption of the abdominal wall accompanied with disturbed abdominal press	25 %
095 Disrupted function of the digestive organs according to degree of nutrition disturbance	100 %
096 Loss of spleen	15 %
097 Partial loss of spleen according to degree of functional disturbance	15 %
098 Post-traumatic consequences of damage to digestive system organs excluding pancreas after conclusion of treatment	15 %
099 Post-traumatic consequences of damage to pancreas	20 %
100 Partial loss of the liver (according to extent)	40 %
101 Post-traumatic consequences of urinary tract injury (excluding kidneys), especially urethral stricture – women	20 %
102 Post-traumatic consequences of urinary tract injury (excluding kidneys), especially urethral stricture – men	30 %
103 Loss of one kidney	20 %
104 Loss of both kidneys	75 %
105 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), mild degree	10 %
106 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), moderate degree	20 %
107 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), severe degree	50 %
108 Urinary bladder or urethral fistula	50 %
109 Hydrocele	5 %
110 Loss of one ovary below 45 years of age	10 %
111 Loss of one ovary above 45 years of age	1 %
112 Loss of both ovaries below 45 years of age	35 %
113 Loss of both ovaries above 45 years of age	10 %
114 Loss of uterus below 45 years of age	40 %
115 Loss of uterus above 45 years of age	3 %
116 Loss of one testicle	10 %
117 Loss of both testicles or impotence below 45 years of age (as verified with penile plethysmograph)	35 %
118 Loss of both testicles or impotence from 46 to 60 years of age (as verified with penile plethysmograph)	20 %
119 Loss of penis or severe penile deformities below 45 years of age	40 %
120 Loss of penis or severe penile deformities from 46 to 60 years of age	20 %
121 Loss of penis or severe penile deformities above 60 years of age	10 %
122 Post-traumatic deformities of female genital organs	40 %
123 Stercoral fistula according to location and extent of reaction in surrounding tissues	60 %
124 Incompetency of anal sphincters, partial	20 %
125 Incompetency of anal sphincters, complete	60 %
126 Post-traumatic rectal or anal stenosis, mild degree	10 %
127 Post-traumatic rectal or anal stenosis, moderate degree	20 %
128 Post-traumatic rectal or anal stenosis, severe degree	60 %
6) Spinal and spinal cord injuries	
129 Restricted mobility of the spine, mild degree	10 %
130 Restricted mobility of the spine, moderate degree	25 %
131 Restricted mobility of the spine, severe degree	55 %
132 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, mild degree	25 %
133 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, moderate degree	40 %
134 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, severe degree	100 %

7) Pelvic injuries	
135 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in women below 45 years of age	65 %
136 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in women above 45 years of age	50 %
137 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in men	50 %
8) Upper extremity injuries	
Judgement on the right side is understood as damage to the dominant upper extremity, while the judgement on the left side as that to the nondominant upper extremity.	
138 Loss of one upper extremity in the shoulder joint or in the region between the elbow and shoulder joints, right-sided	70 %
139 Loss of one upper extremity in the shoulder joint or in the region between the elbow and shoulder joints, left-sided	60 %
140 Complete shoulder joint stiffness in unfavourable position (complete abduction, adduction or positions close to these), right-sided	35 %
141 Complete shoulder joint stiffness in unfavourable position (complete abduction, adduction or positions close to these), left-sided	30 %
142 Complete shoulder joint stiffness in favourable position (abduction 50, flexion 40–45 , internal rotation 20 degrees), right -sided	30 %
143 Complete shoulder joint stiffness in favourable position (abduction 50, flexion 40–45 , internal rotation 20 degrees), left-sided	25 %
144 Restricted range of movement of one shoulder joint of mild degree (raising arms in forward route, forward raising incomplete above 135 degrees), right-sided	5 %
145 Restricted range of movement of one shoulder joint of mild degree (raising arms in forward route, forward raising incomplete above 135 degrees), left-sided	4 %
146 Restricted range of movement of one shoulder joint of moderate degree (raising arms in forward route to 135 degrees), right-sided	10 %
147 Restricted range of movement of the shoulder joint of moderate degree (raising arms in forward route to 135 degrees), left-sided	8 %
148 Restricted range of movement of the shoulder joint of severe degree (raising arms in forward route to 90 degrees), right-sided	18 %
149 Restricted range of movement of the shoulder joint of severe degree (raising arms in forward route to 90 degrees), left-sided	15 %
150 Recurring post-traumatic shoulder joint dislocation on the right side (more than 3 occasions of reposition by physician, dislocation is verified by X-ray)	15 %
151 Recurring post-traumatic shoulder joint dislocation on the left side (more than 3 occasions of reposition by physician, dislocation is verified by X-ray)	12 %
152 Irreparable acromioclavicular joint dislocation on the right side (Tossy II and III)	5 %
153 Irreparable acromioclavicular joint dislocation on the left side (Tossy II and III)	4 %
154 Pseudoarthrosis of the right humerus bone	40 %
155 Pseudoarthrosis of the left humerus bone	30 %
156 Chronic bone marrow inflammation after open injuries or after surgical procedures necessary to treat the consequences of injury on the right side	30 %
157 Chronic bone marrow inflammation after open injuries or after surgical procedures necessary to treat the consequences of injury on the left side	25 %
158 Irreparable sternoclavicular joint dislocation, right-sided	5 %
159 Irreparable sternoclavicular joint dislocation, left-sided	4 %
160 Permanent consequences after the rupture of long head of biceps brachii muscle on the right side	3 %
161 Permanent consequences after the rupture of long head of biceps brachii muscle on the left side	2 %
9) Damage to the region of the elbow joint and forearm	
162 Complete elbow joint stiffness in unfavourable position (complete extension or complete flexion and positions close to these), right-sided	30 %
163 Complete elbow joint stiffness in unfavourable position (complete extension or complete flexion and positions close to these), left-sided	25 %

164 Complete elbow joint stiffness in favourable position (flexion angle of 90–95 degrees), right-sided	20 %
165 Complete elbow joint stiffness in favourable position (flexion angle of 90–95 degrees), left-sided	16 %
166 Restricted elbow joint mobility on the right side – mild degree	6 %
167 Restricted elbow joint mobility on the left side – mild degree	5 %
168 Restricted mobility of the right elbow joint – moderate degree	12 %
169 Restricted mobility of the left elbow joint – moderate degree	10 %
170 Restricted mobility of the right elbow joint – severe degree	18 %
171 Restricted mobility of the left elbow joint – severe degree	15%
172 Complete stiffness of the radioulnar joints with the impossibility of pronation or supination, in unfavourable position (in maximum pronation or supination), right-sided	20 %
173 Complete stiffness of the radioulnar joints with the impossibility of pronation or supination, in unfavourable position (in maximum pronation or supination), left-sided	16 %
174 Restricted pronation and supination on the right side – severe degree	20 %
175 Restricted pronation and supination on the right side – moderate degree	10 %
176 Restricted pronation and supination on the right side – mild degree	5 %
177 Restricted pronation and supination on the left side – severe degree	16 %
178 Restricted pronation and supination on the left side – moderate degree	8 %
179 Pseudoarthrosis of both forearm bones on the right side	40 %
180 Pseudoarthrosis of both forearm bones on the left side	30 %
181 Pseudoarthrosis of radius none on the right side	30 %
182 Pseudoarthrosis of radius bone on the left side	25 %
183 Pseudoarthrosis of ulna on the right side	20 %
184 Pseudoarthrosis of ulna on the left side	15 %
185 Loose elbow joint on the right side	15 %
186 Loose elbow joint on the left side	10 %
187 Loss of one forearm with preserved elbow joint on the right side	55 %
188 Loss of one forearm with preserved elbow joint on the left side	45%
189 Chronic bone marrow inflammation of the right forearm (only after open injuries or after surgical procedures necessary to treat the consequences of injury)	27 %
190 Chronic bone marrow inflammation of the left forearm (only after open injuries or after surgical procedures necessary to treat the consequences of injury)	22 %
10) Loss of or damage to one hand	
191 Loss of one hand in the wrist, right-sided	50 %
192 Loss of one hand in the wrist, left-sided	45 %
193 Loss of all fingers, possibly including also the metacarpal bones on the right side	50 %
194 Loss of all fingers, possibly including also the metacarpal bones on the left side	42 %
195 Loss of fingers except for the thumb, including metacarpal bones on the right side	45 %
196 Loss of fingers except for the thumb, including metacarpal bones on the left side	38 %
197 Complete stiffness in the wrist in unfavourable position (position in extreme plantar flexion), right-sided	30 %
198 Complete stiffness in the wrist in unfavourable position (position in extreme plantar flexion), left-sided	25 %
199 Complete stiffness in the wrist in unfavourable position (position in extreme dorsal flexion), right-sided	30 %
200 Complete stiffness in the wrist in unfavourable position (position in extreme dorsal flexion), left-sided	25 %
201 Complete stiffness in the wrist in favourable position (position of dorsal flexion of 20–40 degrees), right-sided	20 %
202 Complete stiffness in the wrist in favourable position (position of dorsal flexion of 20–40 degrees), left-sided	17 %
203 Pseudoarthrosis of the scaphoid bone on the right side	15 %
204 Pseudoarthrosis of the scaphoid bone on the left side	12 %
205 Restricted mobility of the right wrist – severe degree	20 %
206 - Restricted mobility of the right wrist – moderate degree	18 %
207 Restricted mobility of the right wrist – mild degree	6 %
208 Restricted mobility of the left wrist – severe degree	17 %
209 Restricted mobility of the left wrist – moderate degree	10 %
210 Restricted mobility of the left wrist – mild degree	5 %
211 Looseness of the right wrist (as confirmed with X-ray or US investigation) – severe degree	20 %
212 Looseness of the right wrist (as confirmed with X-ray or US investigation) – moderate degree	15 %
213 Looseness of the right wrist (as confirmed with X-ray or US investigation) – mild degree	10 %
214 Looseness of the left wrist (as confirmed with X-ray or US investigation) – severe degree	15 %
215 Looseness of the left wrist (as confirmed with X-ray or US investigation) – moderate degree	10 %
216 Looseness of the left wrist (as confirmed with X-ray or US investigation) – mild degree	8 %
11) Damage of the thumb	
217 Loss of the distal phalanx of the thumb on the right side	9 %
218 Loss of the distal phalanx of the thumb on the left side	7 %
219 Loss of the thumb together with the metacarpal bone on the right side	25 %
220 Loss of the thumb together with the metacarpal bone on the left side	21 %
221 Loss of both thumb phalanges on the right side	18 %
222 Loss of both thumb phalanges on the left side	15 %
223 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme flexion) on the right side	8 %
224 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme flexion) on the left side	7 %
225 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme hyperextension) on the right side	7 %
226 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme hyperextension) on the left side	6 %
227 Complete stiffness in the interphalangeal joint of the thumb in favourable position (mild semi-flexion) on the right side	6 %
228 Complete stiffness in the interphalangeal joint of the thumb in favourable position (mild semi-flexion) on the left side	5 %
229 Complete stiffness in the carpometacarpal joint of the right thumb	6 %
230 Complete stiffness in the carpometacarpal joint of the left thumb	5 %
231 Restricted mobility of the carpometacarpal joint of the thumb according to degree, right-sided	9 %
232 Restricted mobility of the carpometacarpal joint of the thumb according to degree, left-sided	7 %
233 Complete stiffness of all thumb joints in unfavourable position, right-sided	25 %
234 Complete stiffness of all thumb joints in unfavourable position, left sided	21 %
235 Complete stiffness of the carpometacarpal joint of the thumb in unfavourable position (full abduction or adduction) on the right side	9 %
236 Complete stiffness of the carpometacarpal joint of the thumb in unfavourable position (full abduction or adduction) on the left side	7 %

237 Complete stiffness of the carpometacarpal joint of the thumb in favourable position (mild opposition) on the right side	6 %
238 Complete stiffness of the carpometacarpal joint of the thumb in favourable position (mild opposition) on the left side	5 %
239 Permanent consequences after Bennett's fracture healed in a wrong position with persisting subluxation, except for benefit payment for functional disturbance, on the right side	3 %
240 Permanent consequences after Bennett's fracture healed in a wrong position with persisting subluxation, except for benefit payment for functional disturbance, on the left side	2 %
12) Disturbed grasping function of the thumb as part of restricted mobility of the carpometacarpal joint	
241 of mild degree on the right side	2 %
242 of mild degree on the left side	1,5 %
243 of moderate degree on the right side	4 %
244 of moderate degree on the left side	3 %
245 of severe degree on the right side	6 %
246 of severe degree on the left side	5 %
Disturbance of grasping function of the thumb as part of restricted mobility of the interphalangeal joint	
247 of mild degree on the right side	2 %
248 of mild degree on the left side	1 %
249 of moderate degree on the right side	4 %
250 of moderate degree on the left side	3 %
251 of severe degree on the right side	6 %
252 of severe degree on the left side	5 %
Disturbance of grasping function of the thumb as part of restricted mobility of the carpometacarpal joint	
253 of mild degree on the right side	2 %
254 of mild degree on the left side	1 %
255 of moderate degree on the right side	6 %
256 of moderate degree on the left side	5 %
257 of severe degree on the right side	9 %
258 of severe degree on the left side	7 %
13) Damage to forefinger	
259 Loss of the distal phalanx of the right forefinger – it is not possible to judge the disturbance of the grasping function	4 %
260 Loss of the distal phalanx of the left forefinger – it is not possible to judge the disturbance of the grasping function	3 %
261 Loss of two phalanges of the right forefinger – it is not possible to judge the disturbance of the grasping function	8 %
262 Loss of two phalanges of the left forefinger – it is not possible to judge the disturbance of the grasping function	7 %
263 Loss of all three phalanges of the right forefinger – it is not possible to judge the disturbance of the grasping function	12 %
264 Loss of all three phalanges of the left forefinger – it is not possible to judge the disturbance of the grasping function	10 %
265 Loss of the forefinger with the metacarpal bone on the right side – it is not possible to judge the disturbance of the grasping function	15 %
266 Loss of the forefinger with the metacarpal bone on the left side – it is not possible to judge the disturbance of the grasping function	13 %
267 Complete stiffness of all three forefinger joints in extreme extension on the right side	12 %
268 Complete stiffness of all three forefinger joints in extreme extension on the left side	10 %
269 Complete stiffness of all three forefinger joints in extreme flexion on the right side	15 %
270 Complete stiffness of all three forefinger joints in extreme flexion on the left side	12 %
271 Impossibility of full extension of any of the interphalangeal joints of the right forefinger, with preserved grasping function	2 %
272 Impossibility of full extension of any of the interphalangeal joints of the left forefinger, with preserved grasping function	1 %
273 Disturbance of grasping function of the right forefinger to full closure, 1–3 cm missing to the palm	4 %
274 Disturbance of grasping function of the left forefinger to full closure, 1–3 cm missing to the palm	3 %
275 Disturbance of grasping function of the right forefinger to full closure, 3–4 cm missing to the palm	12 %
276 Disturbance of grasping function of the left forefinger to full closure, 3–4 cm missing to the palm	10 %
277 Disturbance of grasping function of the right forefinger to full closure, more than 4 cm missing to the palm	15 %
278 Disturbance of grasping function of the left forefinger to full closure, more than 4 cm missing to the palm	12 %
279 Impossibility to fully extend the metacarpophalangeal joint of the forefinger with abduction disturbance, right-sided	3 %
280 Impossibility to fully extend the metacarpophalangeal joint of the forefinger with abduction disturbance, left-sided	2 %
14) Damage to the middle, ring, and little fingers	
281 Loss of one whole finger together with the respective metacarpal bone on the right side – the grasping function cannot be judged	10 %
282 Loss of one whole finger together with the respective metacarpal bone on the left side – the grasping function cannot be judged	9 %
283 Loss of all 3 phalanges or 2 phalanges with stiffness of the metacarpophalangeal joint on the right side – the grasping function cannot be judged	8 %
284 Loss of all 3 phalanges or 2 phalanges with stiffness of the metacarpophalangeal joint on the left side – the grasping function cannot be judged	7 %
285 Loss of 2 phalanges of a finger with preserved function of the metacarpophalangeal joint on the right side – the grasping function cannot be judged	6 %
286 Loss of 2 phalanges of a finger with preserved function of the metacarpophalangeal joint on the left side – the grasping function cannot be judged	5 %
287 Loss of one distal phalanx of one of the above fingers on the right side – the grasping function cannot be judged	4 %
288 Loss of one distal phalanx of one of the above fingers on the left side – the grasping function cannot be judged	3 %
289 Loss of the apex of one of the fingers on both the right and left side – the grasping function cannot be judged	2 %
290 Complete stiffness of all 3 joints of one finger in extreme extension or flexion (in a position preventing the function of the neighbouring fingers) on the right side	9 %
291 Complete stiffness of all 3 joints of one finger in extreme extension or flexion (in a position preventing the function of the neighbouring finger) on the left side	7 %
292 Disturbance of grasping function of a finger, 1 to 3 cm are missing to complete closure on the right side	4 %
293 Disturbance of grasping function of a finger, 1 to 3 cm are missing to complete closure on the left side	3 %
294 Disturbance of grasping function of a finger, 3 to 4 cm are missing to complete closure on the right side	6 %
295 Disturbance of grasping function of a finger, 3 to 4 cm are missing to complete closure on the left side	5 %
296 Disturbance of grasping function of a finger, more than 4 cm are missing to complete closure on the right side	8 %
297 Disturbance of grasping function of a finger, more than 4 cm are missing to complete closure on the left side	6 %
298 Impossibility to completely extend one of the interphalangeal joints with preserved grasping function of	1,5 %

the fingers, on the right side	
299 Impossibility to completely extend one of the interphalangeal joints with preserved grasping function of the fingers, on the left side	1 %
300 Impossibility to completely extend one of the metacarpophalangeal joints of a finger with disturbance of abduction, on the right side	2 %
301 Impossibility to completely extend one of the metacarpophalangeal joints of a finger with disturbance of abduction, on the left side	1 %
15) Traumatic disturbances of the nerves of upper extremities	
The judgement already includes the possibly present vasomotor and trophic disturbances.	
302 Traumatic disturbance of the right axillary nerve	30 %
303 Traumatic disturbance of the left axillary nerve	25 %
304 Traumatic disturbance of the trunk of the radial nerve with involvement of all innervated muscles, on the right side	45 %
305 Traumatic disturbance of the trunk of the radial nerve with involvement of all innervated muscles, on the left side	37 %
306 Traumatic disturbance of the radial nerve with preserved function of the triceps brachii muscle, on the right side	35 %
307 Traumatic disturbance of the radial nerve with preserved function of the triceps brachii muscle, on the left side	27 %
308 Traumatic disturbance of the right musculocutaneous nerve	30 %
309 Traumatic disturbance of the left musculocutaneous nerve	20 %
310 Traumatic disturbance of the trunk of the right ulnar nerve with involvement of all innervated muscles	40 %
311 Traumatic disturbance of the trunk of the left ulnar nerve with involvement of all innervated muscles	33 %
312 Traumatic disturbance of the distal part of the ulnar nerve with preserved function of the flexor carpi ulnaris muscle and of part of the flexor digitorum profundus muscle, on the right side	30 %
313 Traumatic disturbance of the distal part of the ulnar nerve with preserved function of the flexor carpi ulnaris muscle and of part of the flexor digitorum profundus muscle, on the left side	25 %
314 Traumatic disturbance of the trunk of the median nerve with involvement of all innervated muscles, on the right side	30 %
315 Traumatic disturbance of the trunk of the median nerve with involvement of all innervated muscles, on the left side	25 %
316 Traumatic disturbance of the distal part of the median nerve, with involvement of mainly the thenar muscles, on the right side	15 %
317 Traumatic disturbance of the distal part of the median nerve, with involvement of mainly the thenar muscles, on the left side	12 %
318 Traumatic disturbance of all three nerves, possibly also of the whole brachial plexus, on the right side	60 %
319 Traumatic disturbance of all three nerves, possibly also of the whole brachial plexus, on the left side	50 %
16) Lower extremity injuries	
320 Loss of one lower extremity in the hip joint or in the region between the hip and knee joints	60 %
321 Pseudoarthrosis of femur or necrosis of the femoral head	40 %
322 Endoprosthesis of the hip joint except for the judgment of restricted mobility of the joint	15 %
323 Chronic inflammation of the bone marrow of the femur, only after open fractures or after surgical procedures necessary to treat the consequences of injury	25 %
324 Decreased length of one lower extremity to 2 cm – absolute shortening	1 %
325 Decreased length of one lower extremity to 4 cm – absolute shortening	5 %
326 Decreased length of one lower extremity to 6 cm – absolute shortening	15 %
327 Decreased length of one lower extremity above 6 cm – absolute shortening	25 %
328 Post-traumatic deformities of femur (healed fractures) with axial or rotational deviation, for every whole 5 degrees of deviation (as demonstrated in X-ray)	5 %
329 Hip joint dislocation	20 %
330 Deviations above 45 degrees are judged as the loss of one extremity	50 %
Complete hip joint stiffness:	
331 in unfavourable position (full adduction or abduction, extension or flexion, and positions similar to these)	20 %
332 in favourable position (slight abduction and neutral position or negligible flexion)	10 %
333 Restricted mobility of the hip joint, mild degree	10 %
334 Restricted mobility of the hip joint, moderate degree	30 %
335 Restricted mobility of the hip joint, severe degree	40 %
17) Damage to the knee joint	
336 Knee joint dislocation	20 %
Complete stiffness of the knee joint in unfavourable position:	
337 full extension or flexion above the angle of 20 degrees	30 %
338 flexion above 30 degrees	45 %
339 Complete stiffness of the knee joint in favourable position (flexion angle 15 to 20 degrees)	25 %
340 Endoprosthesis in the region of the knee joint (in addition to the assessment of movement in the joint)	15 %
341 Restricted mobility of the knee joint, mild degree, but not after TEP implantation	8 %
342 Restricted mobility of the knee joint, moderate degree	12 %
343 Restricted mobility of the knee joint, severe degree	25 %
344 Looseness of the knee joint as part of insufficiency of one collateral ligament	5 %
345 Looseness of the knee joint as part of insufficiency of the anterior or posterior cruciate ligament	12 %
346 Looseness of the knee joint as part of insufficiency of the anterior and posterior cruciate ligaments	25 %
347 Permanent consequences after surgical removal of one meniscus (according to the extent of the removed part – at least 1/3 of the meniscus, demonstration with surgical protocol/findings, restricted mobility is necessary)	5 %
348 Permanent consequences after surgical removal of both menisci (according to the extent of the removed parts – at least 1/3 of the menisci, demonstration with surgical protocol/findings, restricted mobility is necessary)	10 %
349 Permanent consequences after the removal of the patella including atrophy of femoral and crural muscles	25 %
18) Damage to the shank (crus)	
Loss of one lower extremity in the shank:	
350 with preserved knee	45 %
351 with stiff knee joint	50 %
352 Pseudoarthrosis of tibia or both crural bones	40 %
353 Chronic bone marrow inflammation of one crural bone, only after open injuries or after surgical procedures necessary to treat the consequences of injury	22 %
354 Post-traumatic crural deformities as a result of healing of fractures in axial or rotational deviation (the deviations must be demonstrated in X-ray), for every 5 degrees	5 %
355 Deviations above 45 degrees are assessed as the loss of shank	50 %
19) Damage in the region of the ankle joint	
356 Loss of one foot in the ankle joint or below the joint	40 %
357 Loss of sole in Chopart's joint	30 %
358 Loss of sole in Lisfranc joint of below the joint	25 %

359 Complete stiffness of the ankle joint in unfavourable position (dorsal flexion or major plantar flexion above 20 degrees)	30 %
360 Complete stiffness of the ankle joint in rectangular position	25 %
361 Complete stiffness of the ankle joint in favourable position (plantar flexion from 5 to 20 degrees)	20 %
362 Restricted ankle joint mobility, mild degree	6 %
363 Restricted ankle joint mobility, moderate degree	12 %
364 Restricted ankle joint mobility, severe degree	20 %
365 Restricted foot pronation and supination	12 %
366 Complete loss of foot pronation and supination	15 %
367 Looseness of the ankle joint (demonstration with X-ray or US is necessary)	20 %
368 Flatfoot or clubfoot as a result of injury/trauma and other post-traumatic ankle and foot deformities	25 %
369 Chronic bone marrow inflammation in the region of tarsus and metatarsus and the calcaneus, only after open injuries or after surgical procedures necessary to treat the consequences of injury	15 %
20) Damage in the foot region	
370 Loss of all toes	15 %
371 Loss of both great toe phalanges	10 %
372 Loss of both great toe phalanges together with the metatarsal bone or its part	15 %
373 Loss of the great toe end phalanx	3 %
374 Loss of another toe (including the little toe), for each toe	2 %
375 Loss of the little toe together with the metatarsal bone or its part	10 %
376 Complete stiffness of the interphalangeal joint of great toe	3 %
377 Complete stiffness of the metatarsophalangeal joint of great toe	7 %
378 Complete stiffness of both great toe joints	10 %
379 Restricted mobility in the interphalangeal joint of great toe	3 %
380 Restricted mobility of the metatarsophalangeal joint of great toe	7 %
381 Disturbed function of any toe other than great toe, for each toe	1 %
382 Post-inflammatory circulatory and trophic disturbances in one lower extremity	15 %
383 Posttraumatic and trophic disturbances of both lower extremities	30 %
384 Post-traumatic muscle atrophy in the lower extremities with unrestricted range of joint movements, in the thigh (femur)	5 %
385 Post-traumatic muscle atrophy in the lower extremities with unrestricted range of joint movements, in the shank	3 %
21) Traumatic disturbances of the nerves of lower extremity	
The judgement already includes possibly present vasomotor and trophic disturbances.	
386 Traumatic disturbance of the sciatic nerve	50 %
387 Traumatic disturbance of the femoral nerve	30 %
388 Traumatic disturbance of the obturator nerve	20 %
389 Traumatic disturbance of the trunk of the tibial nerve with involvement of all innervated muscles	35 %
390 Traumatic disturbance of the distal part of the tibial nerve with involvement of the function of the toes	5 %
391 Traumatic disturbance of the trunk of the fibular nerve with involvement of all innervated muscles	30 %
392 Traumatic disturbance of the deep branch of the fibular nerve	20 %
393 Traumatic disturbance of the superficial branch of the fibular nerve	10 %
22) Other types of injury	
394 Extensive flat scars from 0.5 to 15% of body surface	10 %
395 Extensive flat scars above 15% of body surface	40 %
396 Post-traumatic pain without functional damage	is not covered
397 Loss of vitality of one tooth	is not covered
398 Loss of tooth less than 50 degrees	is not covered
399 Mental disturbances caused by injury	are not covered
400 Hardness of hearing, unilateral, mild degree	is not covered
401 Loss, chipping off of and damage to deciduous teeth and artificial tooth replacements	is not covered

Special insurance conditions for insurance of the type
RIDER FOR CASE OF PERMANENT CONSEQUENCES OF A CHILD´S ACCIDENT WITH PROGRESSIVE BENEFIT CTN2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for case of permanent consequences of accident with progressive benefit CTN2 (hereinafter only "SPC CTN2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CTN2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CTN2.
3. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider**.

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event and what is understood by "progressive benefit"?

1. **An insured event within this rider is an accident if it leaves permanent consequences and these permanent consequences are diagnosed at the insured person by the relevant doctor within 3 years from the accident**. Permanent consequences mean physical or functional bodily injury that is declared as permanent status after termination of treatment by the relevant doctor.
2. In case of an insured event the insurance company will pay the benefit to the beneficiary **in the amount of the relevant percentage from the sum assured valid as of the day of the insured event's rise multiplied by so-called progression coefficient according to the below-mentioned chart**. This percentage for calculation of benefit payment is set in dependence on the scope and nature of bodily injury assessed by the relevant specialist doctor of the insurance company on the basis of submitted medical records of the insured person, however, always only up to the maximum percentage of the benefit mentioned for individual types of permanent consequences in the Supplement to these SPC CTN2.

Set percentage from the sum assured for individual types of permanent consequences	Progression coefficient
1–25 % including	1
26–50 % including	2
51–75 % including	3
76–100 %	4

3. **If some of the permanent consequences of accident designated in the Supplement to these SPC CTN2 under the numbers 011-016, 019-020, 046-047, 059 and 062-066 represent the insured event, the insurance company will also pay so-called „child's benefit" above the scope of the benefit according to paragraph 2 of this Article. The amount of "child's benefit"** is equal to the level of the relevant percentage from the sum assured valid as of the insured event's date whereas this percentage is set in the way described in paragraph 2 of this Article. Child's benefit is not multiplied by progression coefficient.
4. If more organs or bodily parts are damaged by a single accident, the relevant percentages from the sum assured (maximum % of benefit) mentioned for individual types of permanent after-affects in the Supplement to these SPC CTN2 are added up. **The benefit may be set on the maximum level of 100 % from the sum assured (before multiplication by the progression coefficient) due to one insured event.**
5. **If the after-effect of a single accident is a multiple injury of a single organ, extremity or part of the body, the benefit for this handicap will be determined by the insurance company according to the highest suffered level of disablement of the given organ, extremity or part of the body that means not by summary of the percentages from the sum assured corresponding with all individual injuries of the same organ, extremity or part of the body of the insured person.**
6. **In case of a partial loss of an organ or a partial loss of its function the level of benefit payment will be derived from the benefit for complete loss of organ or complete loss of its function.** In case of permanent consequences of the accident, which are not explicitly mentioned in the Supplement to these conditions, the insurance company will determine the benefit level on the basis of a medical comparison of their severity with the mentioned consequences.
7. **If the accident results in an injury of such a bodily part of the insured person, which was handicapped/injured already before the start of this rider in any way, the assessment of these consequences will be decreased proportionally in such a way that it corresponds with the real consequences of the given accident.** The insurance company will use percentages from the sum assured mentioned in the Supplement to these SPC CTN2 for assessment of injury that existed already before the start of this rider.
8. If the insured person dies during examination of the insured event before benefit payment for permanent consequences of accident according to this rider, however, not due to the consequences of this accident, the insurance company will pay the amount, which corresponds with the scope of permanent consequences of the insured person's accident at the time of his/her death without multiplication by progression coefficient.
9. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. An insured event is reported by the insured person or by his/her legal representative.
10. **The rider does not lapse by an insured event**.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise if the permanent consequences of accident occurred in direct or indirect connection with congenital disorders of the insured child and/or in case of accidents arisen as their result.**
2. **The right to benefit payment does not arise if the permanent consequences of accident occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Mental disorder of the insured person;**
   d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**
   e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   f) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**

g) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**

h) **Professional operation of a sport by the insured person;**

i) **Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**

j) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**

k) **Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**

l) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation. This is not valid if a situation described in Art. 2 paragraph 8 of these SPC CTN2 occurs.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider himself/herself or through his/her legal representative (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability and this by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
3. If a period is set for a certain act in these SPC CTN2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CTN2 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CTN2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CTN2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CTN2 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CTN2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also another profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating

to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF RIDER CTN2

Definition of terms for purposes of benefit payment determination:

1. Restricted mobility compared to the healthy side or compared to common scope of mobility by 10.1 % to 25 % is understood as light level of restricted mobility.

2. Restricted mobility compared to the healthy side or compared to common scope of mobility by 25.1 % to 50 % is understood as middle level of restricted mobility.

3. Restricted mobility compared to the healthy side or compared to common scope of mobility by more than 50 % is considered as high level of restricted mobility.

Permanent consequences:	Maximum % of benefit:
1) Head and sensory organ injuries	
001 Complete cranial vault defect in the extent to 2 cm^2	5 %
002 Complete cranial vault defect in the extent to 5 cm^2	10 %
003 Complete cranial vault defect in the extent to 10 cm^2	15 %
004 Complete cranial vault defect above 10 cm^2	25 %
005 Mild objective symptoms or subjective complaints found through medical observation without objective findings after severe head injuries	20 %
006 Severe neurological brain disturbances after severe head injury according to degree	100 %
007 Subjective complaints after severe injuries to other bodily parts without objective findings as found through medical observation	15 %
008 Loss of jaws	60 %
009 Restricted mobility of the lower jaw (with partial mouth opening to 1 cm)	5 %
010 Complete loss of mobility of the lower jaw	25 %
011 Traumatic disturbance of the facial nerve, mild degree	10 %
012 Traumatic disturbance of the facial nerve, severe degree	15 %
013 Traumatic damage to the trigeminal nerve according to degree	15 %
014 Facial damage accompanied by functional disturbances or arousing feelings of compassion or loathing, mild degree	10 %
015 Facial damage accompanied by functional disturbances or arousing feelings of compassion or loathing, moderate degree	20 %
016 Facial damage accompanied by functional disturbances or arousing feeling of compassion or loathing, severe degree	35 %
017 Cerebral fistula after skull base injury (liquorrhea)	15 %
018 Nasal deformation with functional disturbance of patency	10 %
019 Total loss of nose without stenosis	15 %
020 Total loss of nose with stenosis	25 %
021 Loss of nasal tip	8 %
022 Chronic atrophic mucous membrane inflammation after burn (chemical) or burn	10 %
023 Nasal septum perforation	5 %
024 Chronic purulent posttraumatic sinusitis	10 %
025 Loss of smell	10 %
026 Loss of taste	5 %
027a Reduced visual acuity in one eye – vague and blurred vision	10 %
027b **Reduced visual acuity in one eye – keeping of outlines, distinction of light** and darkness	25 %
027c Total loss of vision in one eye	50 %
028a Reduced visual acuity in both eyes - vague and blurred vision	20 %
028b **Reduced visual acuity in both eyes – keeping of outlines, distinction of light** and darkness	50 %
028c Total loss of vision in both eyes	100 %
029 Loss of vision, for each anatomical loss of an eye addition of	5 %
030 Concentric and non-concentric narrowing of the visual field	20 %
031 Loss of the crystalline lens in one eye, including accommodation disturbance below 25 years of age	15 %
032 Loss of the crystalline lens in one eye, including accommodation disturbance below 35 years of age	10 %
033 Loss of the crystalline lens in one eye, including accommodation disturbance above 35 years of age	5 %
034 Traumatic disturbance of oculomotor nerves or equilibrium disturbance of oculomotor muscles	25 %
035 Disturbed patency of the lacrimal duct in one eye	5 %
036 Disturbed of patency of the lacrimal ducts in both eyes	10 %
037 Wrong position of the eyelashes not correctable with surgery on one eye	5 %
038 Wrong position of the eyelashes not correctable with surgery on both eyes	10 %
039 Ptosis of the upper lid not correctable with surgery, one-sided	15 %
040 Ptosis of the upper lid not correctable with surgery, bilateral	60 %
041 Traumatic disturbance of accommodation, one-sided	5 %
042 Traumatic disturbance of accommodation, bilateral	8 %
043 Posttraumatic lagophthalmos not correctable with surgery, one-sided	10 %
044 Posttraumatic lagophthalmos not correctable with surgery, bilateral	15 %
045 Dilated pupil (mydriasis) and paralysis (in an eye with preserved vision) according to degree	5 %
046 Loss of one auricle	10 %
047 Loss of both auricles	15 %
048 Hardness of hearing, one-sided, moderate degree	5 %
049 Hardness of hearing, one-sided, severe degree	12 %
050 Hardness of hearing, bilateral, mild degree	10 %
051 Hardness of hearing, bilateral, moderate degree	20 %
052 Hardness of hearing, bilateral, severe degree	35 %
053 Deafness in one ear	35 %
054 Deafness in both ears	45 %
055 Labyrinthine disturbance, one-sided, according to degree	10 %
056 Labyrinthine disturbance, bilateral, according to degree	30 %
057 Permanent post-traumatic tympanic membrane perforation without manifest secondary infection	5 %
058 Chronic purulent otitis media demonstrated to be directly caused by injury	15 %
059 Complete loss of tongue	40 %
060 Loss of more than one half of the tongue	10 %
061 States after tongue injury with tissue defect or cicatricial deformations (only if loss of voice has not been judged already)	15 %
Deforming scars in the facial part of the head:	
062 lip defects	5 %
063 elongated keloid scars from 2 cm to 4 cm	2 %
064 elongated keloid scars above 4 cm	4 %
065 elongated scars from 2 cm to 4 cm	1 %
066 elongated scars above 4 cm	2 %
2) Damage to dentition (caused by injury)	
067 Loss of one tooth	1 %
068 Loss of each subsequent tooth	1 %
3) Neck injuries	
069 Stenosis of larynx or trachea, mild degree	15 %
070 Stenosis of larynx or trachea, moderate degree	30 %
071 Stenosis of larynx or trachea, severe degree	60 %
072 Loss of voice (aphonia)	20 %
073 Aggravated speech as a result of damage to the vocal apparatus or voice disturbance as a result of insufficient vocal cords	20 %
074 Loss of speech as a result of damage to the vocal apparatus	25 %
075 Status post tracheal or laryngeal injury with permanently inserted cannula	35 %
076 Status post tracheotomy with permanently inserted cannula (cannot be judged concurrently with stenosis of larynx and aphonia)	50 %
4) Thoracic, pulmonary, cardiac or oesophageal injuries	

077 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), mild degree	10 %
078 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), moderate degree	20 %
079 Restricted movements of the chest and adhesions between lungs and chest wall verified clinically (spirometry investigation), severe degree	30 %
080 Other consequences of lung injury according to degree and extent, one-sided (spirometry investigation)	40 %
081 Other consequences of lung injury according to degree and extent, bilateral (spirometry investigation)	80 %
082 Loss of one lung	35 %
083 Restricted pulmonary function from 10%	5 %
084 Restricted pulmonary function from 25 %	15 %
085 Restricted pulmonary function from 50 %	25 %
086 Restricted pulmonary function from 75%	40 %
087 Complete loss of one breast (in women)	15 %
088 Complete loss of both breasts (in women)	30 %
089 Cardiac disturbance (only after direct injury, clinically verified, according to degree, ECG investigation)	80 %
090 Oesophageal fistula	30 %
091 Post-traumatic oesophageal stenosis, mild degree	10 %
092 Post-traumatic oesophageal stenosis, moderate degree	30 %
093 Post-traumatic oesophageal stenosis, severe degree	60 %
5) Injuries affecting abdomen, digestive organs, urinary tract and genital organs	
094 Disruption of the abdominal wall accompanied with disturbed abdominal press	25 %
095 Disrupted function of the digestive organs according to degree of nutrition disturbance	100 %
096 Loss of spleen	15 %
097 Partial loss of spleen according to degree of functional disturbance	15 %
098 Post-traumatic consequences of damage to digestive system organs excluding pancreas after conclusion of treatment	15 %
099 Post-traumatic consequences of damage to pancreas	20 %
100 Partial loss of the liver (according to extent)	40 %
101 Post-traumatic consequences of urinary tract injury (excluding kidneys), especially urethral stricture – women	20 %
102 Post-traumatic consequences of urinary tract injury (excluding kidneys), especially urethral stricture – men	30 %
103 Loss of one kidney	20 %
104 Loss of both kidneys	75 %
105 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), mild degree	10 %
106 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), moderate degree	20 %
107 Post-traumatic consequences of kidney and urinary tract injuries (including secondary infection), severe degree	50 %
108 Urinary bladder or urethral fistula	50 %
109 Hydrocele	5 %
110 Loss of one ovary below 45 years of age	10 %
111 Loss of one ovary above 45 years of age	1 %
112 Loss of both ovaries below 45 years of age	35 %
113 Loss of both ovaries above 45 years of age	10 %
114 Loss of uterus below 45 years of age	40 %
115 Loss of uterus above 45 years of age	3 %
116 Loss of one testicle	10 %
117 Loss of both testicles or impotence below 45 years of age (as verified with penile plethysmograph)	35 %
118 Loss of both testicles or impotence from 46 to 60 years of age (as verified with penile plethysmograph)	20 %
119 Loss of penis or severe penile deformities below 45 years of age	40 %
120 Loss of penis or severe penile deformities from 46 to 60 years of age	20 %
121 Loss of penis or severe penile deformities above 60 years of age	10 %
122 Post-traumatic deformities of female genital organs	40 %
123 Stercoral fistula according to location and extent of reaction in surrounding tissues	60 %
124 Incompetency of anal sphincters, partial	20 %
125 Incompetency of anal sphincters, complete	60 %
126 Post-traumatic rectal or anal stenosis, mild degree	10 %
127 Post-traumatic rectal or anal stenosis, moderate degree	20 %
128 Post-traumatic rectal or anal stenosis, severe degree	60 %
6) Spinal and spinal cord injuries	
129 Restricted mobility of the spine, mild degree	10 %
130 Restricted mobility of the spine, moderate degree	25 %
131 Restricted mobility of the spine, severe degree	55 %
132 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, mild degree	25 %
133 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, moderate degree	40 %
134 Post-traumatic spinal and spinal cord or spinal root damage with permanent objective symptoms, severe degree	100 %
7) Pelvic injuries	
135 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in women below 45 years of age	65 %
136 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in women above 45 years of age	50 %
137 Severe pelvic injury with disturbed statics of the spine and function of lower extremities in men	50 %
8) Upper extremity injuries	
Judgement on the right side is understood as damage to the dominant upper extremity, while the judgement on the left side as that to the nondominant upper extremity.	
138 Loss of one upper extremity in the shoulder joint or in the region between the elbow and shoulder joints, right-sided	70 %
139 Loss of one upper extremity in the shoulder joint or in the region between the elbow and shoulder joints, left-sided	60 %
140 Complete shoulder joint stiffness in unfavourable position (complete abduction, adduction or positions close to these), right-sided	35 %
141 Complete shoulder joint stiffness in unfavourable position (complete abduction, adduction or positions close to these), left-sided	30 %
142 Complete shoulder joint stiffness in favourable position (abduction 50, flexion 40–45 , internal rotation 20 degrees), right -sided	30 %
143 Complete shoulder joint stiffness in favourable position (abduction 50, flexion 40–45 , internal rotation 20 degrees), left-sided	25 %
144 Restricted range of movement of one shoulder joint of mild degree (raising arms in forward route, forward raising incomplete above 135 degrees), right-sided	5 %
145 Restricted range of movement of one shoulder joint of mild degree (raising arms in forward route, forward raising incomplete above 135 degrees), left-sided	4 %
146 Restricted range of movement of one shoulder joint of moderate degree (raising arms in forward route to 135 degrees), right-sided	10 %
147 Restricted range of movement of the shoulder joint of moderate degree (raising arms in forward route to 135 degrees), left-sided	8 %
148 Restricted range of movement of the shoulder joint of severe degree (raising arms in forward route to 90 degrees), right-sided	18 %
149 Restricted range of movement of the shoulder joint of severe degree (raising arms in forward route to 90 degrees), left-sided	15 %
150 Recurring post-traumatic shoulder joint dislocation on the right side (more than 3 occasions of reposition by physician, dislocation is verified by X-ray)	15 %
151 Recurring post-traumatic shoulder joint dislocation on the left side (more than 3 occasions of reposition by physician, dislocation is verified by X-ray)	12 %
152 Irreparable acromioclavicular joint dislocation on the right side (Tossy II and III)	5 %

153 Irreparable acromioclavicular joint dislocation on the left side (Tossy II and III)	4 %
154 Pseudoarthrosis of the right humerus bone	40 %
155 Pseudoarthrosis of the left humerus bone	30 %
156 Chronic bone marrow inflammation after open injuries or after surgical procedures necessary to treat the consequences of injury on the right side	30 %
157 Chronic bone marrow inflammation after open injuries or after surgical procedures necessary to treat the consequences of injury on the left side	25 %
158 Irreparable sternoclavicular joint dislocation, right-sided	5 %
159 Irreparable sternoclavicular joint dislocation, left-sided	4 %
160 Permanent consequences after the rupture of long head of biceps brachii muscle on the right side	3 %
161 Permanent consequences after the rupture of long head of biceps brachii muscle on the left side	2 %
9) Damage to the region of the elbow joint and forearm	
162 Complete elbow joint stiffness in unfavourable position (complete extension or complete flexion and positions close to these), right-sided	30 %
163 Complete elbow joint stiffness in unfavourable position (complete extension or complete flexion and positions close to these), left-sided	25 %
164 Complete elbow joint stiffness in favourable position (flexion angle of 90–95 degrees), right-sided	20 %
165 Complete elbow joint stiffness in favourable position (flexion angle of 90–95 degrees), left-sided	16 %
166 Restricted elbow joint mobility on the right side – mild degree	6 %
167 Restricted elbow joint mobility on the left side – mild degree	5 %
168 Restricted mobility of the right elbow joint – moderate degree	12 %
169 Restricted mobility of the left elbow joint – moderate degree	10 %
170 Restricted mobility of the right elbow joint – severe degree	18 %
171 Restricted mobility of the left elbow joint – severe degree	15%
172 Complete stiffness of the radioulnar joints with the impossibility of pronation or supination, in unfavourable position (in maximum pronation or supination), right-sided	20 %
173 Complete stiffness of the radioulnar joints with the impossibility of pronation or supination, in unfavourable position (in maximum pronation or supination), left-sided	16 %
174 Restricted pronation and supination on the right side – severe degree	20 %
175 Restricted pronation and supination on the right side – moderate degree	10 %
176 Restricted pronation and supination on the right side – mild degree	5 %
177 Restricted pronation and supination on the left side – severe degree	16 %
178 Restricted pronation and supination on the left side – moderate degree	8 %
179 Pseudoarthrosis of both forearm bones on the right side	40 %
180 Pseudoarthrosis of both forearm bones on the left side	30 %
181 Pseudoarthrosis of radius none on the right side	30 %
182 Pseudoarthrosis of radius bone on the left side	25 %
183 Pseudoarthrosis of ulna on the right side	20 %
184 Pseudoarthrosis of ulna on the left side	15 %
185 Loose elbow joint on the right side	15 %
186 Loose elbow joint on the left side	10 %
187 Loss of one forearm with preserved elbow joint on the right side	55 %
188 Loss of one forearm with preserved elbow joint on the left side	45%
189 Chronic bone marrow inflammation of the right forearm (only after open injuries or after surgical procedures necessary to treat the consequences of injury)	27 %
190 Chronic bone marrow inflammation of the left forearm (only after open injuries or after surgical procedures necessary to treat the consequences of injury)	22 %

10) Loss of or damage to one hand	
191 Loss of one hand in the wrist, right-sided	50 %
192 Loss of one hand in the wrist, left-sided	45 %
193 Loss of all fingers, possibly including also the metacarpal bones on the right side	50 %
194 Loss of all fingers, possibly including also the metacarpal bones on the left side	42 %
195 Loss of fingers except for the thumb, including metacarpal bones on the right side	45 %
196 Loss of fingers except for the thumb, including metacarpal bones on the left side	38 %
197 Complete stiffness in the wrist in unfavourable position (position in extreme plantar flexion), right-sided	30 %
198 Complete stiffness in the wrist in unfavourable position (position in extreme plantar flexion), left-sided	25 %
199 Complete stiffness in the wrist in unfavourable position (position in extreme dorsal flexion), right-sided	30 %
200 Complete stiffness in the wrist in unfavourable position (position in extreme dorsal flexion), left-sided	25 %
201 Complete stiffness in the wrist in favourable position (position of dorsal flexion of 20–40 degrees), right-sided	20 %
202 Complete stiffness in the wrist in favourable position (position of dorsal flexion of 20–40 degrees), left-sided	17 %
203 Pseudoarthrosis of the scaphoid bone on the right side	15 %
204 Pseudoarthrosis of the scaphoid bone on the left side	12 %
205 Restricted mobility of the right wrist – severe degree	20 %
206 - Restricted mobility of the right wrist – moderate degree	18 %
207 Restricted mobility of the right wrist – mild degree	6 %
208 Restricted mobility of the left wrist – severe degree	17 %
209 Restricted mobility of the left wrist – moderate degree	10 %
210 Restricted mobility of the left wrist – mild degree	5 %
211 Looseness of the right wrist (as confirmed with X-ray or US investigation) – severe degree	20 %
212 Looseness of the right wrist (as confirmed with X-ray or US investigation) – moderate degree	15 %
213 Looseness of the right wrist (as confirmed with X-ray or US investigation) – mild degree	10 %
214 Looseness of the left wrist (as confirmed with X-ray or US investigation) – severe degree	15 %
215 Looseness of the left wrist (as confirmed with X-ray or US investigation) – moderate degree	10 %
216 Looseness of the left wrist (as confirmed with X-ray or US investigation) – mild degree	8 %
11) Damage of the thumb	
217 Loss of the distal phalanx of the thumb on the right side	9 %
218 Loss of the distal phalanx of the thumb on the left side	7 %
219 Loss of the thumb together with the metacarpal bone on the right side	25 %
220 Loss of the thumb together with the metacarpal bone on the left side	21 %
221 Loss of both thumb phalanges on the right side	18 %
222 Loss of both thumb phalanges on the left side	15 %
223 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme flexion) on the right side	8 %
224 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme flexion) on the left side	7 %
225 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme hyperextension) on the right side	7 %
226 Complete stiffness in the interphalangeal joint of the thumb in unfavourable position (extreme hyperextension) on the left side	6 %
227 Complete stiffness in the interphalangeal joint of the thumb in favourable position (mild semi-flexion) on the right side	6 %

228 Complete stiffness in the interphalangeal joint of the thumb in favourable position (mild semi-flexion) on the left side	5 %
229 Complete stiffness in the carpometacarpal joint of the right thumb	6 %
230 Complete stiffness in the carpometacarpal joint of the left thumb	5 %
231 Restricted mobility of the carpometacarpal joint of the thumb according to degree, right-sided	9 %
232 Restricted mobility of the carpometacarpal joint of the thumb according to degree, left-sided	7 %
233 Complete stiffness of all thumb joints in unfavourable position, right-sided	25 %
234 Complete stiffness of all thumb joints in unfavourable position, left sided	21 %
235 Complete stiffness of the carpometacarpal joint of the thumb in unfavourable position (full abduction or adduction) on the right side	9 %
236 Complete stiffness of the carpometacarpal joint of the thumb in unfavourable position (full abduction or adduction) on the left side	7 %
237 Complete stiffness of the carpometacarpal joint of the thumb in favourable position (mild opposition) on the right side	6 %
238 Complete stiffness of the carpometacarpal joint of the thumb in favourable position (mild opposition) on the left side	5 %
239 Permanent consequences after Bennett's fracture healed in a wrong position with persisting subluxation, except for benefit payment for functional disturbance, on the right side	3 %
240 Permanent consequences after Bennett's fracture healed in a wrong position with persisting subluxation, except for benefit payment for functional disturbance, on the left side	2 %
12) Disturbed grasping function of the thumb as part of restricted mobility of the carpometacarpal joint	
241 of mild degree on the right side	2 %
242 of mild degree on the left side	1,5 %
243 of moderate degree on the right side	4 %
244 of moderate degree on the left side	3 %
245 of severe degree on the right side	6 %
246 of severe degree on the left side	5 %
Disturbance of grasping function of the thumb as part of restricted mobility of the interphalangeal joint	
247 of mild degree on the right side	2 %
248 of mild degree on the left side	1 %
249 of moderate degree on the right side	4 %
250 of moderate degree on the left side	3 %
251 of severe degree on the right side	6 %
252 of severe degree on the left side	5 %
Disturbance of grasping function of the thumb as part of restricted mobility of the carpometacarpal joint	
253 of mild degree on the right side	2 %
254 of mild degree on the left side	1 %
255 of moderate degree on the right side	6 %
256 of moderate degree on the left side	5 %
257 of severe degree on the right side	9 %
258 of severe degree on the left side	7 %
13) Damage to forefinger	
259 Loss of the distal phalanx of the right forefinger – it is not possible to judge the disturbance of the grasping function	4 %
260 Loss of the distal phalanx of the left forefinger – it is not possible to judge the disturbance of the grasping function	3 %
261 Loss of two phalanges of the right forefinger – it is not possible to judge the disturbance of the grasping function	8 %
262 Loss of two phalanges of the left forefinger – it is not possible to judge the disturbance of the grasping function	7 %
263 Loss of all three phalanges of the right forefinger – it is not possible to judge the disturbance of the grasping function	12 %
264 Loss of all three phalanges of the left forefinger – it is not possible to judge the disturbance of the grasping function	10 %
265 Loss of the forefinger with the metacarpal bone on the right side – it is not possible to judge the disturbance of the grasping function	15 %
266 Loss of the forefinger with the metacarpal bone on the left side – it is not possible to judge the disturbance of the grasping function	13 %
267 Complete stiffness of all three forefinger joints in extreme extension on the right side	12 %
268 Complete stiffness of all three forefinger joints in extreme extension on the left side	10 %
269 Complete stiffness of all three forefinger joints in extreme flexion on the right side	15 %
270 Complete stiffness of all three forefinger joints in extreme flexion on the left side	12 %
271 Impossibility of full extension of any of the interphalangeal joints of the right forefinger, with preserved grasping function	2 %
272 Impossibility of full extension of any of the interphalangeal joints of the left forefinger, with preserved grasping function	1 %
273 Disturbance of grasping function of the right forefinger to full closure, 1–3 cm missing to the palm	4 %
274 Disturbance of grasping function of the left forefinger to full closure, 1–3 cm missing to the palm	3 %
275 Disturbance of grasping function of the right forefinger to full closure, 3–4 cm missing to the palm	12 %
276 Disturbance of grasping function of the left forefinger to full closure, 3–4 cm missing to the palm	10 %
277 Disturbance of grasping function of the right forefinger to full closure, more than 4 cm missing to the palm	15 %
278 Disturbance of grasping function of the left forefinger to full closure, more than 4 cm missing to the palm	12 %
279 Impossibility to fully extend the metacarpophalangeal joint of the forefinger with abduction disturbance, right-sided	3 %
280 Impossibility to fully extend the metacarpophalangeal joint of the forefinger with abduction disturbance, left-sided	2 %
14) Damage to the middle, ring, and little fingers	
281 Loss of one whole finger together with the respective metacarpal bone on the right side – the grasping function cannot be judged	10 %
282 Loss of one whole finger together with the respective metacarpal bone on the left side – the grasping function cannot be judged	9 %
283 Loss of all 3 phalanges or 2 phalanges with stiffness of the metacarpophalangeal joint on the right side – the grasping function cannot be judged	8 %
284 Loss of all 3 phalanges or 2 phalanges with stiffness of the metacarpophalangeal joint on the left side – the grasping function cannot be judged	7 %
285 Loss of 2 phalanges of a finger with preserved function of the metacarpophalangeal joint on the right side – the grasping function cannot be judged	6 %
286 Loss of 2 phalanges of a finger with preserved function of the metacarpophalangeal joint on the left side – the grasping function cannot be judged	5 %
287 Loss of one distal phalanx of one of the above fingers on the right side – the grasping function cannot be judged	4 %
288 Loss of one distal phalanx of one of the above fingers on the left side – the grasping function cannot be judged	3 %
289 Loss of the apex of one of the fingers on both the right and left side – the grasping function cannot be judged	2 %

290 Complete stiffness of all 3 joints of one finger in extreme extension or flexion (in a position preventing the function of the neighbouring fingers) on the right side	9 %
291 Complete stiffness of all 3 joints of one finger in extreme extension or flexion (in a position preventing the function of the neighbouring finger) on the left side	7 %
292 Disturbance of grasping function of a finger, 1 to 3 cm are missing to complete closure on the right side	4 %
293 Disturbance of grasping function of a finger, 1 to 3 cm are missing to complete closure on the left side	3 %
294 Disturbance of grasping function of a finger, 3 to 4 cm are missing to complete closure on the right side	6 %
295 Disturbance of grasping function of a finger, 3 to 4 cm are missing to complete closure on the left side	5 %
296 Disturbance of grasping function of a finger, more than 4 cm are missing to complete closure on the right side	8 %
297 Disturbance of grasping function of a finger, more than 4 cm are missing to complete closure on the left side	6 %
298 Impossibility to completely extend one of the interphalangeal joints with preserved grasping function of the fingers, on the right side	1,5 %
299 Impossibility to completely extend one of the interphalangeal joints with preserved grasping function of the fingers, on the left side	1 %
300 Impossibility to completely extend one of the metacarpophalangeal joints of a finger with disturbance of abduction, on the right side	2 %
301 Impossibility to completely extend one of the metacarpophalangeal joints of a finger with disturbance of abduction, on the left side	1 %
15) Traumatic disturbances of the nerves of upper extremities	
The judgement already includes the possibly present vasomotor and trophic disturbances.	
302 Traumatic disturbance of the right axillary nerve	30 %
303 Traumatic disturbance of the left axillary nerve	25 %
304 Traumatic disturbance of the trunk of the radial nerve with involvement of all innervated muscles, on the right side	45 %
305 Traumatic disturbance of the trunk of the radial nerve with involvement of all innervated muscles, on the left side	37 %
306 Traumatic disturbance of the radial nerve with preserved function of the triceps brachii muscle, on the right side	35 %
307 Traumatic disturbance of the radial nerve with preserved function of the triceps brachii muscle, on the left side	27 %
308 Traumatic disturbance of the right musculocutaneous nerve	30 %
309 Traumatic disturbance of the left musculocutaneous nerve	20 %
310 Traumatic disturbance of the trunk of the right ulnar nerve with involvement of all innervated muscles	40 %
311 Traumatic disturbance of the trunk of the left ulnar nerve with involvement of all innervated muscles	33 %
312 Traumatic disturbance of the distal part of the ulnar nerve with preserved function of the flexor carpi ulnaris muscle and of part of the flexor digitorum profundus muscle, on the right side	30 %
313 Traumatic disturbance of the distal part of the ulnar nerve with preserved function of the flexor carpi ulnaris muscle and of part of the flexor digitorum profundus muscle, on the left side	25 %
314 Traumatic disturbance of the trunk of the median nerve with involvement of all innervated muscles, on the right side	30 %
315 Traumatic disturbance of the trunk of the median nerve with involvement of all innervated muscles, on the left side	25 %
316 Traumatic disturbance of the distal part of the median nerve, with involvement of mainly the thenar muscles, on the right side	15 %
317 Traumatic disturbance of the distal part of the median nerve, with involvement of mainly the thenar muscles, on the left side	12 %
318 Traumatic disturbance of all three nerves, possibly also of the whole brachial plexus, on the right side	60 %
319 Traumatic disturbance of all three nerves, possibly also of the whole brachial plexus, on the left side	50 %
16) Lower extremity injuries	
320 Loss of one lower extremity in the hip joint or in the region between the hip and knee joints	60 %
321 Pseudoarthrosis of femur or necrosis of the femoral head	40 %
322 Endoprosthesis of the hip joint except for the judgment of restricted mobility of the joint	15 %
323 Chronic inflammation of the bone marrow of the femur, only after open fractures or after surgical procedures necessary to treat the consequences of injury	25 %
324 Decreased length of one lower extremity to 2 cm – absolute shortening	1 %
325 Decreased length of one lower extremity to 4 cm – absolute shortening	5 %
326 Decreased length of one lower extremity to 6 cm – absolute shortening	15 %
327 Decreased length of one lower extremity above 6 cm – absolute shortening	25 %
328 Post-traumatic deformities of femur (healed fractures) with axial or rotational deviation, for every whole 5 degrees of deviation (as demonstrated in X-ray)	5 %
329 Hip joint dislocation	20 %
330 Deviations above 45 degrees are judged as the loss of one extremity	50 %
Complete hip joint stiffness:	
331 in unfavourable position (full adduction or abduction, extension or flexion, and positions similar to these)	20 %
332 in favourable position (slight abduction and neutral position or negligible flexion)	10 %
333 Restricted mobility of the hip joint, mild degree	10 %
334 Restricted mobility of the hip joint, moderate degree	30 %
335 Restricted mobility of the hip joint, severe degree	40 %
17) Damage to the knee joint	
336 Knee joint dislocation	20 %
Complete stiffness of the knee joint in unfavourable position:	
337 full extension or flexion above the angle of 20 degrees	30 %
338 flexion above 30 degrees	45 %
339 Complete stiffness of the knee joint in favourable position (flexion angle 15 to 20 degrees)	25 %
340 Endoprosthesis in the region of the knee joint (in addition to the assessment of movement in the joint)	15 %
341 Restricted mobility of the knee joint, mild degree, but not after TEP implantation	8 %
342 Restricted mobility of the knee joint, moderate degree	12 %
343 Restricted mobility of the knee joint, severe degree	25 %
344 Looseness of the knee joint as part of insufficiency of one collateral ligament	5 %
345 Looseness of the knee joint as part of insufficiency of the anterior or posterior cruciate ligament	12 %
346 Looseness of the knee joint as part of insufficiency of the anterior and posterior cruciate ligaments	25 %
347 Permanent consequences after surgical removal of one meniscus (according to the extent of the removed part – at least 1/3 of the meniscus, demonstration with surgical protocol/findings, restricted mobility is necessary)	5 %
348 Permanent consequences after surgical removal of both menisci (according to the extent of the removed parts – at least 1/3 of the menisci, demonstration with surgical protocol/findings, restricted mobility is necessary)	10 %
349 Permanent consequences after the removal of the patella including atrophy of femoral and crural muscles	25 %

18) Damage to the shank (crus)	
Loss of one lower extremity in the shank:	
350 with preserved knee	45 %
351 with stiff knee joint	50 %
352 Pseudoarthrosis of tibia or both crural bones	40 %
353 Chronic bone marrow inflammation of one crural bone, only after open injuries or after surgical procedures necessary to treat the consequences of injury	22 %
354 Post-traumatic crural deformities as a result of healing of fractures in axial or rotational deviation (the deviations must be demonstrated in X-ray), for every 5 degrees	5 %
355 Deviations above 45 degrees are assessed as the loss of shank	50 %
19) Damage in the region of the ankle joint	
356 Loss of one foot in the ankle joint or below the joint	40 %
357 Loss of sole in Chopart's joint	30 %
358 Loss of sole in Lisfranc joint of below the joint	25 %
359 Complete stiffness of the ankle joint in unfavourable position (dorsal flexion or major plantar flexion above 20 degrees)	30 %
360 Complete stiffness of the ankle joint in rectangular position	25 %
361 Complete stiffness of the ankle joint in favourable position (plantar flexion from 5 to 20 degrees)	20 %
362 Restricted ankle joint mobility, mild degree	6 %
363 Restricted ankle joint mobility, moderate degree	12 %
364 Restricted ankle joint mobility, severe degree	20 %
365 Restricted foot pronation and supination	12 %
366 Complete loss of foot pronation and supination	15 %
367 Looseness of the ankle joint (demonstration with X-ray or US is necessary)	20 %
368 Flatfoot or clubfoot as a result of injury/trauma and other post-traumatic ankle and foot deformities	25 %
369 Chronic bone marrow inflammation in the region of tarsus and metatarsus and the calcaneus, only after open injuries or after surgical procedures necessary to treat the consequences of injury	15 %
20) Damage in the foot region	
370 Loss of all toes	15 %
371 Loss of both great toe phalanges	10 %
372 Loss of both great toe phalanges together with the metatarsal bone or its part	15 %
373 Loss of the great toe end phalanx	3 %
374 Loss of another toe (including the little toe), for each toe	2 %
375 Loss of the little toe together with the metatarsal bone or its part	10 %
376 Complete stiffness of the interphalangeal joint of great toe	3 %
377 Complete stiffness of the metatarsophalangeal joint of great toe	7 %
378 Complete stiffness of both great toe joints	10 %
379 Restricted mobility in the interphalangeal joint of great toe	3 %
380 Restricted mobility of the metatarsophalangeal joint of great toe	7 %
381 Disturbed function of any toe other than great toe, for each toe	1 %
382 Post-inflammatory circulatory and trophic disturbances in one lower extremity	15 %
383 Posttraumatic and trophic disturbances of both lower extremities	30 %
384 Post-traumatic muscle atrophy in the lower extremities with unrestricted range of joint movements, in the thigh (femur)	5 %
385 Post-traumatic muscle atrophy in the lower extremities with unrestricted range of joint movements, in the shank	3 %
21) Traumatic disturbances of the nerves of lower extremity	
The judgement already includes possibly present vasomotor and trophic disturbances.	
386 Traumatic disturbance of the sciatic nerve	50 %
387 Traumatic disturbance of the femoral nerve	30 %
388 Traumatic disturbance of the obturator nerve	20 %
389 Traumatic disturbance of the trunk of the tibial nerve with involvement of all innervated muscles	35 %
390 Traumatic disturbance of the distal part of the tibial nerve with involvement of the function of the toes	5 %
391 Traumatic disturbance of the trunk of the fibular nerve with involvement of all innervated muscles	30 %
392 Traumatic disturbance of the deep branch of the fibular nerve	20 %
393 Traumatic disturbance of the superficial branch of the fibular nerve	10 %
22) Other types of injury	
394 Extensive flat scars from 0.5 to 15% of body surface	10 %
395 Extensive flat scars above 15% of body surface	40 %
396 Post-traumatic pain without functional damage	is not covered
397 Loss of vitality of one tooth	is not covered
398 Loss of tooth less than 50 degrees	is not covered
399 Mental disturbances caused by injury	are not covered
400 Hardness of hearing, unilateral, mild degree	is not covered
401 Loss, chipping off of and damage to deciduous teeth and artificial tooth replacements	is not covered

Special insurance conditions for insurance of the type
RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (Degree II., III.) CID6
RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (Degree II., III.) CID7

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of disability due to disease or accident (degree II., III.) CID6 and rider for case of disability due to disease or accident (degree II., III.) CID7 (hereinafter only "SPC CID6/CID7") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CID6/CID7 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CID6/CID7.

   These riders can be arranged only as additional insurance to the main life insurance (hereinafter only the „Main coverage"). Unless explicitly mentioned otherwise further in these SPC CID6/CID7, any of the riders SPC CID6 and CID7 specified above is understood by the term rider (in singular).
3. **If provisions about anti-inflation programme are mentioned in GTC, then they do not relate to the rider CID6. If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders CID6 and CID7.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is the insured person's disability as a result of an accident or disease (hereinafter only "disability") of degree II or III. The decisive day when disability occurred is the day mentioned in the assessment of the relevant social security authority about disability.**
2. The insured person's disability represents an insured event only if:
   a) the working ability of the insured person decreased at least by 50 % due to a long-term unfavourable health status of the insured person (however, by 69 % at the most) in case of disability degree II, or at least by 70 % in case of disability degree III,
   b) disability degree II or III (in the sense of meeting the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant social security authority about disability,
   c) a certified copy of this statement on disability will be submitted to the insurance company.
3. At the same time it is valid that **disability does not represent an insured event if the disability caused otherwise than exclusively due to an accident occurs before expiry of the waiting period of 18 months since the rider's start.**
4. The methodology of relevant legal regulations on pension insurance for determination of degree II or III of disability will be used to determine the level of decrease in the insured person's working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
5. In case of an insured event – disability of degree II. or III. – the insurance company will pay a single benefit to the beneficiary in the amount of the arranged sum assured from the rider for case of disability due to disease or accident (Degree II., III.) CID6/CID7.
6. In case of an insured event – disability of degree III **due to the diagnosis "quadriplegia" or "terminal disease"**, the insurance company will pay the benefit on the level of 150 % from the arranged valid sum assured to the beneficiary.
7. The claim to benefit payment has to be proven by a statement on disability issued by the relevant social security authority about disability, in which disability of degree II or III has been acknowledged to the insured person (in the sense of meeting the condition according to paragraph 2 letter a) of this Article).
8. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and ask for benefit payment, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The level of regular premium at the rider for case of disability due to disease or accident (Degree II., III.) CID6 is equal to the multiple of the sum assured for the given rider and the premium rate set in the tariff of charges for the topical age of the insured person. Therefore, premium rates increasing with time (so-called natural premium) are arranged for the given rider, the specific amount of regular premium for the first year of insurance is mentioned in the insurance contract (or in the proposal for change in the insurance contract) and the specific amount of regular premium for each further year of insurance will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written announcement to the policyholder latest 8 weeks before anniversary of the main coverage.

Table of natural rates CID6

Age	15-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65
Rate (in CZK)	20.6	23.1	23.2	26.3	33.8	41.3	63.8	86.3	108.8	108.8

3. The level of regular premium at the rider for case of disability due to disease or accident (Degree II., III.) CID7 is equal to the multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the whole insurance period in dependence on the insured person's age as of the rider's start and on the arranged insurance period.
4. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases; (iii) on the basis of current legal regulation for judgement of conditions and degrees of disability. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 4 of these SPC CID6/CID7.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (which exclusions are arranged)?

1. **The right to benefit payment does not arise if disability occurred in direct or indirect connection with:**
   a) suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
   b) diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;

c) disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;

d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

e) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

f) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;

g) professional operation of sport by the insured person;

h) performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

i) diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;

j) accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;

k) worsening of the insured person's disease, which occurred due to the accident of the insured person;

l) accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Exclusions mentioned in this paragraph under the letters c), g), j) – m) are valid only for case that the disability is result of an accident.

2. If there is an insured event within the period of 18 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider for case of disability due to disease or accident (Degree II., III.) CID6/CID7 lapses due to the insured event as of the end of the insurance period. The rider for case of disability due to disease or accident (Degree I.) CIDA/CIDB of the same insured person lapses at the same time if it was arranged.
4. The rider also lapses as of the day when old age pension is acknowledged to the insured person.
5. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at arrangement of this rider for the purpose of insurance risk and premium level determination, and this especially on the basis of the health questionnaire, which the insured person is obliged to complete truthfully and completely himself/herself or through his/her legitimate representative at the arrangement of this rider (unless exceptionally set otherwise by the insurance company), and possibly also on the basis of reports and medical documentation requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
3. If a period is set for a certain act in these SPC CID6/CID7 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CID6/CID7 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CID6/CID7 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CID6/CID7 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CID6/CID7 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CID6/CID7 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Quadriplegia

Complete or partial paralysis of all four limbs and torso;

Insurance year

Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Terminal disease

Various types of very severe diseases, the course of which is very likely to result in death of the insured person within 12 months (e.g. generalized tumour diseases that have escaped control by treatment or the terminal stages of failure of vitally important organs where transplantation is no more an option in the specific case, e.g. for general damage sustained by the organism);

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (Degree I.) CIDA
RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (Degree I.) CIDB

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of disability due to disease or accident (Degree I.) CIDA and rider for case of disability due to disease or accident (Degree I.) CIDB (hereinafter only "SPC CIDA/CIDB") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CIDA/CIDB are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CIDA/CIDB.

   These riders can be arranged only as additional insurance to the main life insurance (hereinafter only the „Main coverage"). Unless explicitly mentioned otherwise further in these SPC CIDA/CIDB, any of the riders SPC CIDA and CIDB specified above is understood by the term rider (in singular).
3. **If provisions about anti-inflation programme are mentioned in GTC, then they do not relate to the rider CIDA. If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders CIDA and CIDB.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is the insured person's disability as a result of an accident or disease (hereinafter only "disability") of degree I. The decisive day when disability occurred is the day mentioned in the assessment of the relevant social security authority about disability.**
2. The insured person's disability represents an insured event only if:
   a) the working ability of the insured person decreased at least by 35 % due to a long-term unfavourable health status of the insured person (however, by 49 % at the most),
   b) disability degree I (in the sense of meeting the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant social security authority about disability,
   c) a certified copy of this statement on disability will be submitted to the insurance company.
3. At the same time it is valid that **disability does not represent an insured event if the disability caused otherwise than exclusively due to an accident occurs before expiry of the waiting period of 18 months since the rider's start.**
4. The methodology of relevant legal regulations on pension insurance for determination of degree I of disability will be used to determine the level of decrease in the insured person's working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
5. In case of an insured event – disability of degree I. – the insurance company will pay a single benefit to the beneficiary in the amount of the arranged sum assured from the rider for case of disability due to disease or accident (Degree I.) CIDA/CIDB.
6. The claim to benefit payment has to be proven by a statement on disability issued by the relevant social security authority about disability, in which disability of degree I has been acknowledged to the insured person (in the sense of meeting the condition according to paragraph 2 letter a) of this Article).
7. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and ask for benefit payment, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium in case of the rider for case of disability due to disease or accident (Degree I.) CIDA is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the topical age of the insured person. Specific level of regular premium for the first insurance year of this rider, for which it is arranged at the time of increasing premium rate (so-called natural premium), is mentioned in the insurance contract for the first insurance year of the rider (or in the proposal for change in the insurance contract) and specific level of regular premium for each other insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written announcement to the policyholder latest 8 weeks before anniversary of the main coverage.

Table of natural rates CIDA

Age	15-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65
Rate (in CZK)	**9.9**	**11.3**	**15.8**	**20.3**	**24.8**	**38.3**	**51.8**	**65.3**	**74.3**	**74.3**

3. The level of regular premium at the rider for case of disability due to disease or accident (Degree I.) CIDB is equal to the multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the whole insurance period in dependence on the insured person's age as of the rider's start and on the arranged insurance period.
4. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases; (iii) on the basis of current legal regulation for judgement of conditions and degrees of disability. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 4 of these SPC CIDA/CIDB.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise if disability occurred in direct or indirect connection with:**
   a) suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
   b) diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;
   c) disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;

d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

e) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

f) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;

g) professional operation of sport by the insured person;

h) performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

i) diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;

j) accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;

k) worsening of the insured person's disease, which occurred due to the accident of the insured person;

l) accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Exclusions mentioned in this paragraph under the letters c), g), j) – m) are valid only for case that the disability is result of an accident.

2. If there is an insured event within the period of 18 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider for case of disability due to disease or accident (Degree I.) CIDA/CIDB lapses due to the insured event as of the end of the insurance period.
4. The rider also lapses as of the day when old age pension is acknowledged to the insured person.
5. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at arrangement of this rider for the purpose of insurance risk and premium level determination, and this especially on the basis of the health questionnaire, which the insured person is obliged to complete truthfully and completely himself/herself or through his/her legitimate representative at the arrangement of this rider (unless exceptionally set otherwise by the insurance company), and possibly also on the basis of reports and medical documentation requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
3. If a period is set for a certain act in these SPC CIDA/CIDB and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CIDA/CIDB and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CIDA/CIDB to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CIDA/CIDB to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CIDA/CIDB and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CIDA/CIDB and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (DEGREE II., III.) WITH DECREASING SUM ASSURED CID8

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of disability due to disease or accident (Degree II., III.) with desreasing sum assured CID8 (hereinafter only "SPC CID8") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CID8 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CID8.
3. This rider may be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider and what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is the insured person's disability as a result of an accident or disease (hereinafter only "disability") of degree II or III. The decisive day when disability occurred is the day mentioned in the assessment of the relevant social security authority about disability.**
2. The insured person's disability represents an insured event only if:
   a) the working ability of the insured person decreased at least by 50 % due to a long-term unfavourable health status of the insured person (however, by 69 % at the most) in case of disability degree II, or at least by 70 % in case of disability degree III,
   b) disability degree II or III (in the sense of meeting the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant social security authority about disability,
   c) a certified copy of this statement on disability will be submitted to the insurance company.
3. At the same time it is valid that **disability does not represent an insured event if the disability caused otherwise than exclusively due to an accident occurs before expiry of the waiting period of 18 months since the rider's start.**
4. The methodology of relevant legal regulations on pension insurance for determination of degree II or III of disability will be used to determine the level of decrease in the insured person's working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
5. The sum assured is linearly decreasing that means it is decreased by 1/n of the arranged sum assured as of each anniversary where "n" represents the arranged insurance period in years. If there is a change in this rider on the basis of the policyholder's request (change in the sum assured or in the insurance period), the sum assured is decreased by 1/n of the newly arranged sum assured as of each anniversary where "n" represents the newly arranged insurance period rounded to whole years up, rounded to whole thousand Czech crowns up.
6. In case of an insured event – disability of degree II. or III. – the insurance company will pay a single benefit to the beneficiary in the amount of the topically valid sum assured from the rider for case of disability due to disease or accident (Degree II., III.) with decreasing sum assured CID8.
7. In case of an insured event – disability of degree III **due to the diagnosis "quadriplegia" or "terminal disease"**, the insurance company will pay the benefit on the level of 150 % from the arranged valid sum assured to the beneficiary.
8. The claim to benefit payment has to be proven by a statement on disability issued by the relevant social security authority about disability, in which disability of degree II or III has been acknowledged to the insured person (in the sense of meeting the condition according to paragraph 2 letter a) of this Article).
9. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and ask for benefit payment, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured topically valid as of this rider's start and the premium rate set in the tariff of charges for the entire duration of cover in dependence on the age of the insured person as of the rider's start and on the arranged duration of cover; therefore fixed premium rates are arranged for this rider. Only 1 % of premium determined according to the previous sentence is paid during the last 3 years of the rider's duration.
3. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases; (iii) on the basis of current legal regulation for judgement of conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 5 of these SPC CID8.

Article 4 - For which period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise if disability occurred in direct or indirect connection with:**
   a) suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
   b) diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;
   c) disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;
   d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;
   e) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;
   f) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear

fissure, synthesis or another similar reaction, radioactive power or agent;

g) professional operation of sport by the insured person;

h) performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

i) diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;

j) accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;

k) worsening of the insured person's disease, which occurred due to the accident of the insured person;

l) accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Exclusions mentioned in this paragraph under the letters c), g), j) – m) are valid only for case that the disability is result of an accident.

2. If there is an insured event within the period of 18 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider for case of disability due to disease or accident (Degree II., III.) with decreasing sum assured CID8 lapses due to the insured event as of the end of the insurance period. The rider for case of disability due to disease or accident (Degree I.) with decreasing sum assured CIDC of the same insured person lapses at the same time if it was arranged.
4. The rider also lapses as of the day when old age pension is acknowledged to the insured person.
5. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. It is not possible to contractually change the amount of the sum assured or to shorten the duration of cover during the last 5 years of the rider's duration, then it is even not possible to prolong the duration of cover during the last 3 years of this rider's duration.
2. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability, by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
4. If a period is set for a certain act in these SPC CID8 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
5. **The insurance company has the right to perform an adequate change in these SPC CID8 and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CID8 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CID8 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CID8 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CID8 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Quadriplegia
Complete or partial paralysis of all four limbs and torso;

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on

periods among the dates of main coverage anniversaries following one after another;

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Terminal disease
Various types of very severe diseases, the course of which is very likely to result in death of the insured person within 12 months (e.g. generalized tumour diseases that have escaped control by treatment or the terminal stages of failure of vitally important organs where transplantation is no more an option in the specific case, e.g. for general damage sustained by the organism);

Accident
Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type RIDER FOR CASE OF DISABILITY DUE TO DISEASE OR ACCIDENT (DEGREE I.) WITH DECREASING SUM ASSURED CIDC

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of disability due to disease or accident (Degree I.) with decreasing sum assured CIDC (hereinafter only "SPC CIDC") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CIDC are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CIDC.
3. These riders can be arranged only as additional insurance to the main life insurance (hereinafter only the „Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider and what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is the insured person's disability as a result of an accident or disease (hereinafter only "disability") of degree I. The decisive day when disability occurred is the day mentioned in the assessment of the relevant social security authority about disability.**
2. The insured person's disability represents an insured event only if:
   a) the working ability of the insured person decreased at least by 35 % due to a long-term unfavourable health status of the insured person (however, by 49 % at the most)
   b) disability degree I (in the sense of meeting the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant social security authority about disability,
   c) a certified copy of this statement on disability will be submitted to the insurance company.
3. At the same time it is valid that **disability does not represent an insured event if the disability caused otherwise than exclusively due to an accident occurs before expiry of the waiting period of 18 months since the rider's start.**
4. The methodology of relevant legal regulations on pension insurance for determination of degree II or III of disability will be used to determine the level of decrease in the insured person's working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
5. The sum assured is linearly decreasing that means it is decreased by 1/n of the arranged sum assured as of each anniversary where "n" represents the arranged insurance period in years. If there is a change in this rider on the basis of the policyholder's request (change in the sum assured or in the insurance period), the sum assured is decreased by 1/n of the newly arranged sum assured as of each anniversary where "n" represents the newly arranged insurance period rounded to whole years up, rounded to whole thousand Czech crowns up.
6. In case of an insured event – disability of degree I. – the insurance company will pay a single benefit to the beneficiary in the amount of the topically valid sum assured from the rider for case of disability due to disease or accident (Degree I.) with decreasing sum assured CIDC.
7. The claim to benefit payment has to be proven by a statement on disability issued by the relevant social security authority about disability, in which disability of degree I has been acknowledged to the insured person (in the sense of meeting the condition according to paragraph 2 letter a) of this Article).
8. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and ask for benefit payment, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured topically valid as of this rider's start and the premium rate set in the tariff of charges for the entire duration of cover in dependence on the age of the insured person as of the rider's start and on the arranged duration of cover; therefore fixed premium rates are arranged for this rider. Only 1 % of premium determined according to the previous sentence is paid during the last 3 years of the rider's duration.
3. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases; (iii) on the basis of current legal regulation for judgement of conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 5 of these SPC CIDC.

Article 4 - For which period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise if disability occurred in direct or indirect connection with:**
   a) suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
   b) diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;
   c) disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;
   d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;
   e) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;
   f) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;
   g) professional operation of sport by the insured person;
   h) performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

i) **diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;**

j) **accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;**

k) **worsening of the insured person's disease, which occurred due to the accident of the insured person;**

l) **accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**

m) **accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Exclusions mentioned in this paragraph under the letters c), g), j) – m) are valid only for case that the disability is result of an accident.

1. **If there is an insured event within the period of 18 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider for case of disability due to disease or accident (Degree I.) with decreasing sum assured CIDC lapses due to the insured event as of the end of the insurance period.
4. The rider also lapses as of the day when old age pension is acknowledged to the insured person.
5. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. It is not possible to contractually change the amount of the sum assured or to shorten the duration of cover during the last 5 years of the rider's duration, then it is even not possible to prolong the duration of cover during the last 3 years of this rider's duration.
2. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability, by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
4. If a period is set for a certain act in these SPC CIDC and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
5. **The insurance company has the right to perform an adequate change in these SPC CIDC and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CIDC to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CIDC to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CIDC and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CIDC and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the

sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER FOR CASE OF DISABILITY DUE TO ACCIDENT (DEGREE III.) CUD3

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of disability due to accident (degree III.) CUD3 (hereinafter only „SPC CUD3“) create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only “GTC”).
2. Provisions of these SPC CUD3 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CUD3.
3. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the “Main coverage”).
4. **If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is degree III of the insured person’s disability due to an accident.**
2. Disability of the insured person due to an accident represents an insured event only if:
   a) The working ability of the insured person decreased at least by 70 % due to the long-term unfavourable health status of the insured person,
   b) Degree III of disability (in the sense of fulfilment of the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant Social Security Administration,
   c) A certified copy of this statement on disability will be submitted to the insurance company and
   d) The cause for degree III of disability was exclusively the accident of the insured person in the sense of these SPC CUD3.
3. The day of rise of degree III of disability mentioned in the statement on disability of the relevant Social Security Administration is considered as the day of the insured event’s rise. The methodology of relevant legal regulations on pension insurance for determination of degree III of disability will be used to determine the level of decrease in the insured person’s working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
4. In case of an insured event the insurance company will pay the benefit to the beneficiary in the form of an annuity that is paid in regular monthly instalments on the level of 1/12 from the sum assured valid as of the day of the insured event’s rise. The insurance company will start with benefit payment (payment of annuity) starting by the nearest date of premium maturity following after the rise of the insured event and terminate as of the day of premium maturity, as of which the insured person does not prove his/her claim to benefit payment according to paragraph 6 of this Article, however, latest as of the day of this rider’s extinction. **The insurance company will continue with annuity payment also after the extinction of this rider until the insured person has achieved the age of 65 years if this rider lapses:**
   a) In the way according to Art. 6 paragraph 4 of these SPC CUD3 that means by achievement of the maximum age of the insured person for this rider mentioned in the insurance contract or
   b) In the way according to Art. 6 paragraph 1 of these SPC CUD3 that means by lapse of the main coverage if the main coverage lapsed by expiry of the arranged duration of cover or by the insured event of reaching the arranged end of insurance by the insured person.
5. **The annual annuity value will increase by 5 %** (from the sum assured valid as of the day of the insured event’s rise) **after the start of annuity payment always as of the anniversary day of the rider’s start.**
6. **The insured person is obliged to prove his/her claim to benefit payment at the claim’s notification and further on every further year of the benefit payment duration (annuity payment) before the day of premium maturity, which by its designation accords with the date of premium maturity when benefit payment started if he/she is interested in further benefit payment by the insurance company,** however, longest until the rider’s lapse. The claim is proven by the statement on disability issued by the relevant Social Security Administration at the claim’s notification where degree III of disability is acknowledged to the insured person (in the sense of fulfilment of the condition according to paragraph 2 letter a) of this Article) and claim to benefit payment is proven by updated statements on disability of the relevant Social Security Administration in the following years where duration of degree III of disability will be confirmed within a check-up of the level of decrease in the insured person’s working ability (in the sense of fulfilment of the conditions according to paragraph 2 letter a) of this Article).
7. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed “Claim notification” form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company’s self service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and he/she is not even able to ask for benefit payment, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.
8. **The rider does not lapse by an insured event**.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges.
3. Premium rates mentioned in the tariff of charges for this rider were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases (iii) current legal regulation for judgement of disability conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 8 paragraph 5. of these SPC CUD3.

Article 4 - For which period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

The right to benefit payment does not arise if disability occurred in direct or indirect connection with:

a) Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;

b) Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;

c) Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;

d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

e) Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept

or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

f) Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;Professional operation of a sport by the insured person;

g) Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

h) Disease or accidents that occurred before the insurance start with exception of cases when a health care questionnaire was completed at the conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the existence of the mentioned disease;

i) Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;

j) Worsening of the insured person's disease, which occurred due to the accident of the insured person;

k) Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

l) Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator. Exceptions mentioned in this paragraph under the letters d), f), i) – l) are valid only for case that the disability is result of an accident.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider lapses as of the day when old age pension is acknowledged to the insured person.
4. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
5. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The insurance company also reserves the right to examine the health status of the insured person, his/her working ability including fulfilment of conditions for acknowledgement of degree III of disability during the period of benefit payment according to this rider (during the period of annuity payment).**
3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
4. If a period is set for a certain act in these SPC CUD2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
5. **The insurance company has the right to perform an adequate change in these SPC CUD3 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CUD3 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CUD3 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CUD3 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CUD3 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type WAIVER OF PREMIUM PAYMENT RIDER DUE TO DISEASE OR ACCIDENT WITH ANNUITY PAYMENT (DISABILITY OF DEGREE III.) COP2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for waiver of premium payment rider due to disease or accident with annuity payment (disability of degree III) COP2 (hereinafter only "SPC COP2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC COP2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC COP2. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
3. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider and what benefit payment am I entitled to in case of an insured event?

1. It is valid for this rider that the policyholder is always understood as the insured person.
2. **An insured event within this rider is degree III of the insured person's disability**. **The decisive day when disability occurred is the day mentioned in the assessment of the relevant social security authority about disability.**
3. Disability of the insured person represents an insured event only if:
   a) The working ability of the insured person decreased at least by 70 % due to the long-term unfavourable health status of the insured person,
   b) Degree III of disability (in the sense of fulfilment of the condition according to letter a) of this paragraph) will be acknowledged to the insured person within statement on disability by the relevant Social Security Administration,
   c) A certified copy of this statement on disability will be submitted to the insurance company.
4. It is valid at the same time that **disability is not an insured event if this disability that was caused otherwise than exclusively due to the accident occurred before expiry of the waiting period of 18 months from the rider's start.**
5. The methodology of relevant legal regulations on pension insurance for determination of degree III of disability will be used to determine the level of decrease in the insured person's working ability with regard to the gainful activities that the insured person could perform before this decrease in the working ability.
6. **In case of an insured event benefit provision by the insurance company is:**
   a) Waiver of premium payment of the policyholder for the main coverage and also for all riders arranged in the insurance contract (premium is paid by the insurance company for the policyholder). The insurance company will start with benefit provision (it will waive the policyholder of the obligation to pay premium) starting by the nearest date of premium maturity that follows after the rise of the insured event and terminates as of the day of premium maturity, as of which the insured person does not prove his/her claim to benefit provision according to paragraph 7 of this Article, however, latest as of the day of this rider's lapse,
   b) And benefit payment in the form of an annuity if it is explicitly arranged to this rider that is paid for the period of the waiver of payment duration in regular monthly instalments, whose level is arranged in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and according to the choice of the insured person made at notification of the claim.
7. **The insured person is obliged to prove his/her claim to benefit provision at the claim's notification and further on every further year of the benefit provision duration before the day of premium maturity, which by its designation accords with the date of premium maturity when benefit provision started if he/she is interested in further benefit provision by the insurance company,** however, longest until the rider's lapse. The claim is proven by the statement on disability issued by the relevant Social Security Administration at the claim's notification where degree III of disability is acknowledged to the insured person (in the sense of fulfilment of the condition according to paragraph 3 letter a) of this Article) and claim to benefit provision is proven by updated statements on disability of the relevant Social Security Administration in the following years where duration of degree III of disability will be confirmed within a check-up of the level of decrease in the insured person's working ability (in the sense of fulfilment of the condition according to paragraph 3 letter a) of this Article).
8. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and he/she is not even able to ask for benefit provision in the form of an annuity, also a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit provision, is entitled to report the insured event. In such a case the benefit in the form of annuity will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.
9. **The rider does not lapse by an insured event.** If new disability of degree III is acknowledged by the relevant Social Security Administration after termination of benefit provision or if the conditions according to paragraph 3 of this Article are met after termination of benefit provision, it is possible to report this fact as a new insured event.

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this insurance and the premium rate set in the tariff of charges for the entire period of the insurance duration in dependence on the length of the arranged duration of cover and the age of the insured person as of the insurance start. In this case the sum assured is understood as the summary of regular premium for the main coverage and all other riders arranged in the insurance contract (with exception of this rider COP2 and rider Cardif CRDF) before taking possible discounts on premium into consideration.
3. Premium rates mentioned in the tariff of charges for this rider were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases (iii) current legal regulation for judgement of disability conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 5. of these SPC COP2.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (which exclusions are arranged)?

1. **The right to benefit payment does not arise if disability occurred in direct or indirect connection with:**
   a) suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;
   b) diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done

and which is not necessary from medical point of view including all interventions not prescribed by a doctor;

c) disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;

d) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

e) radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

f) effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;

g) professional operation of sport by the insured person;

h) performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

i) diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;

j) accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;

k) worsening of the insured person's disease, which occurred due to the accident of the insured person;

l) accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Exclusions mentioned in this paragraph under the letters c), g), j) – m) are valid only for case that the disability is result of an accident.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider lapses as of the day when old age pension is acknowledged to the insured person.
4. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
5. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The insurance company also reserves the right to examine the health status of the insured person, his/her working ability including fulfilment of conditions for acknowledgement of degree III of disability during the period of benefit provision according to this rider, i.e. during the period of waiver of premium payment.**
3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
4. If a period is set for a certain act in these SPC COP2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
5. **The insurance company has the right to perform an adequate change in these SPC COP2 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC COP2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC COP2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC COP2 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC COP2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type RIDER FOR CASE OF THE CHILD´S DEPENDENCE ON CARE OF ANOTHER PERSON DUE TO DISEASE OR ACCIDENT CDI2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for case of the child's dependence on care of another person due to disease or accident CDI2 (hereinafter only "SPC CDI2") create an integral part of the contract and are supplemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CDI2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CDI2.
3. This rider may be arranged only as supplementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider and what benefit payment am I entitled to in case of an insured event?

1. **An insured event is dependence of the insured child on care of another person in the sense of Art. 2 paragraph 2 of these SPC CDI2 caused by disease or accident of the insured child that arises during the insurance duration, however, this only under the condition that this event occurred at the insured person only after expiry of the waiting period of 3 months from the day of this rider's start. The waiting period is not applied in case when dependence on care of another person arose explicitly as result of accident.**
2. For the purposes of these SPC CDI2, dependence on help of another person is understood as dependence of the insured child of degree III. or IV. on help of another individual according to Act No. 108/2006 Coll., on Social Services, as amended. Dependence of the insured child on care of another person must be documented to the insurance company by an officially authenticated copy of the decision of the competent authority in the area of social services.
3. The decisive day when dependence of the child on care of another person occurred, is the day mentioned in the decision of the competent authority in the area of social services.
4. In case of an insured event, the insurance company will pay a single benefit in the amount of the arranged sum assured to the beneficiary.
5. **An insured event is reported to the seat of the insurance company without an unnecessary delay, and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. The insured event is reported by the insured person or by his/her legitimate representative.

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to the multiple of the sum assured for this rider and the premium rate set in the tariff of charges.

Article 4 - For which period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (which exclusions are arranged)?

1. The right to benefit payment does not arise if the insured event occurred in direct or indirect connection with:
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**
   d) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   e) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   f) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**
   g) **Professional operation of sport by the insured person;**
   h) **Diseases or accidents that occurred before start of the insurance, with exception of cases when the health questionnaire was completed at conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the mentioned disease existence at the insured person;**
   i) **Accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease, or in connection with chronic health complications existing before such an accident;**
   j) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**
   k) **Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**
   l) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Exclusions mentioned in this paragraph under the letters c), g), i) – l) are valid only for case that it is about dependency on help of another person as result of accident.

2. **If there is an insured event within the period of 3 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.**
3. **Other exclusions from benefit payment are set by relevant provisions of GTC.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider lapses due to the insured event as of the end of the insurance period.
4. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
5. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at arrangement of this rider for the purpose of insurance risk and premium level determination, and this especially on the basis of the health questionnaire, which the insured person is obliged to complete truthfully and completely himself/herself or through his/her legitimate representative at the arrangement of this rider (unless exceptionally set otherwise by the insurance company), and possibly also on the basis of reports and medical documentation requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
3. If a period is set for a certain act in these SPC CDI2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. The insurance company has the right to perform an adequate change in these SPC CDI2 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CDI2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company. The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CDI2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CDI2 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CDI2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's own force or external forces independently of the will of the insured that occurred during the period of insurance/rider and resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER FOR CASE OF CANCER IN ADULTS CZR1
RIDER FOR CASE OF CANCER IN ADULTS CZR3
RIDER FOR CASE OF SEVERE DISEASES OF ADULTS CZV1
RIDER FOR CASE OF SEVERE DISEASES OF ADULTS CZV3

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for rider for case of cancer in adults CZR1, rider for case of cancer in adults CZR3, rider for case of severe diseases of adults CZV1 and rider for case of severe diseases of adults CZV3 (hereinafter only "SPC CZR1/CZR3 and CZV1/CZV3") create an integral part of the contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CZR1/CZR3 and CZV1/CZV3 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CZR1/CZR3 and CZV1/CZV3.
3. These riders CZR1, CZR3, CZV1 a CZV3 can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage"). Unless explicitly mentioned otherwise further in these SPC CZR1/CZR3 and CZV1/CZV3, any of the riders CZR1, CZR3, CZV1and CZV3 specified above is understood by the term rider (in singular).
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is diagnosis identification of some of the severe diseases or undergoing some of the surgeries (specified in the Supplement in both cases), however, this only under the condition that this event occurred at the insured person only after expiry of the waiting period of 6 months from the day of this rider's start and at the same time:**
   a) At the rider for case of cancer in adults **CZR1 and** at the rider for case of cancer in adults **CZR3 the insurance coverage concerns only the disease cancer described in Part A of the Supplement,**
   b) At the rider for case of severe diseases of adults **CZV1 and** at the rider for case of severe diseases of adults **CZV3 the insurance coverage concerns all severe diseases or surgeries described in Part B of the Supplement.** It is described in the Supplement, which day is considered as start of the insured event's rise at individual severe diseases/surgeries.
2. In case of an insured event the insurance company will pay the benefit to the beneficiary in the amount of the arranged sum assured or a part thereof, and this in dependence on the type of severe disease/underwent surgery that is subject of the given insured event. Particular level of benefit payment for individual diagnoses or percentage value of benefit payment in relation to the arranged sum assured is mentioned in the Supplement.
3. **If the level of paid benefit achieves less than 100 % of the sum assured, i.e. 10 % or 30 % according to certain diagnoses specified in the Supplement, the rider does not lapse by such an insured event. The original sum assured will be decreased by the value of the paid benefit after benefit payment realisation to the topical/available sum assured, and this with effect as of the day of the insured event. Also the amount of regular premium will be decreased in a corresponding way as of the same day. The number of insured events according to this paragraph is limited only by the value of the originally arranged sum assured to this rider (on the maximum level of 100 % or 150 % when applying the diagnosis of terminal disease).** Therefore if the topical/available sum assured does not achieve the relevant amount of benefit to the severe disease/underwent surgery in question with regard to previous benefit payments, the insurance company will decrease the payment of such last benefit in a corresponding way. **So it is not possible to pay more than 100 % of the originally arranged sum assured to this rider in summary. When applying the diagnosis of terminal disease, it is not possible to pay more than 150 % of the originally arranged sum assured to this rider in summary.**
4. **If the beneficiary has already received a partial benefit payment from this rider according to the previous paragraph, subsequent changes in this rider are excluded (this is valid also for exchange of this rider for any other of the four riders CZR1, CZR3, CZV1 and CZV3 regulated by these special insurance conditions).**
5. **If a so-called terminal disease** (i.e. relevant severe disease in terminal stage as specified in the Supplement to all variants of this rider CZR1, CZR3, CZV1 or CZV3) **is reported as an insured event, the insurance company reserves the right to examine the insured person's health status or the submitted documents about the insured person's health status and to pay only 100 % of the sum assured for this rider according to standard diagnosis of the given disease in cases when the doctor appointed by the insurance company does not confirm existence of terminal disease in the sense of the definition mentioned in the Supplement.**
6. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and he/she is not even able to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium for rider for case of cancer in adults CZR1 and for case of severe diseases of adults CZV1 is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the topical age of the insured person. Specific level of regular premium for the first insurance year of this rider, for which it is arranged at the time of increasing premium rate (so-called natural premium), is mentioned in the insurance contract for the first insurance year of the rider (or in the proposal for change in the insurance contract) and specific level of regular premium for each other insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written announcement to the policyholder latest 8 weeks before anniversary of the main coverage.
3. The amount of regular premium for case of cancer in adults CZR3 and for case of severe diseases of adults CZV3 is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the entire insurance period in dependence on the age of the insured person as of the rider's start and on the arranged duration of cover.
4. Premium rates mentioned in the tariff of charges for this rider were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases (iii) current legal regulation for judgement of disability conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 4. of these SPC CZR1/CZR3 and CZV1/CZV3.

Table of natural rates CZR1									
Age	15-20	21-25	26-35	36-40	41-45	46-50	51-55	56-60	61-65
Rate (in CZK)	**15**	**18**	**19**	**29**	**48**	**77**	**110**	**151**	**175**

Table of natural rates CZV1										
Age	15-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65
Rate (in CZK)	**40**	**50**	**55**	**60**	**70**	**95**	**130**	**180**	**250**	**320**

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in a few exceptional cases that are specified in the Supplement at the diagnoses' description of some severe diseases/surgeries.**
2. **The right to benefit payment also does not arise if the severe disease or surgery occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   d) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   e) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**
3. **If an insured event occurs within the period of 6 months from the day when the sum assured of this rider has been increased on the basis of the policyholder's request, the insurance company will decrease benefit payment to the lowest sum assured valid for the last 6 months before the day of this insured event's rise.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. **If the level of paid benefit achieves 100 % of the sum assured or 150 % of the sum assured when applying the terminal disease diagnosis, the rider lapses as of the day of the given insured event's rise.**
4. **The rider lapses from the start and the insurance company will return the entire premium paid for this rider to the policyholder if the day of the insured event's rise occurs before expiry of the arranged waiting period of 6 months from the start of this rider.**
5. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability and this by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
3. If a period is set for a certain act in these SPC CZR1/CZR3 and CZV1/CZV3 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CZR1/CZR3 and CZV1/CZV3 and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CZR1/CZR3 and CZV1/CZV3 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CZR1/CZR3 and CZV1/CZV3 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CZR1/CZR3 and CZV1/CZV3 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CZR1/CZR3 and CZV1/CZV3 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company.

Insurance year

Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another.

Supplement

Supplement to these SPC CZR1/CZR3 and CZV1/CZV3 and SPC CZR5/CZV5 containing specification of diagnoses of all severe diseases/surgeries that are covered by this rider including mentioning possible exceptions from benefit payment, decisive day, which is considered as the day of the insured event's rise, percentage value of benefit payment in relation to the arranged sum assured and documents that are obligatorily submitted to the insurance company at the claim's notification.

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF THE RIDER FOR CANCER IN ADULTS AND THE RIDER OF SEVERE DISEASES OF ADULTS

Part A - Variant Rider for case of cancer in adults (CZR1, CZR3 and CZR5)

Benefit in % of sum assured	Name of diagnosis	Description of diagnosis	Obligatorily submitted documents at claim's notification to insurance company + day of claim's rise:
150%	**Terminal disease as a result of cancer**	These are diseases, the course of which is very likely to result in the death of the insured within 12 months. The diseases are generalized tumour diseases that have escaped control by treatment. Both diagnosis and prognosis must be determined by a relevant specialist physician, i.e. oncologist, based on histological and other specialist investigations. The attending oncologist must confirm that this is a condition affecting the insured and that all available treatment options for the malignant disease have been exhausted, and that only symptomatic and palliative treatment can be used. The insurance company is entitled to review the health condition of the insured and submitted documents describing the health condition through the mediation of a specialist who shall be designated by the insurance company.	Report by attending physician - oncologist that confirms this diagnosis, its stage, and the treatment and prognosis of the disease. Day of claim's rise is the day, as of which the oncologist has determined the terminal stage of the disease satisfying the provided description.
100%	**Cancer**	Cancer is a disease manifesting with the occurrence of malignant tumours with characteristic uncontrolled growth and spread of malignant cells and their penetration in healthy tissue. These diseases also include leukaemia, sarcomas, malignant diseases of the lymphatic system (e.g. Hodgkin's disease), malignant disease of the bone marrow and metastatic forms of skin cancer. **The right to insurance benefit does not arise in the following cases:** a) tumour diseases in the presence of HIV infection; b) malignant skin melanomas in stage 1A depth (less than 1 mm, II or III without ulceration) according to the valid classification AJCC from 2002; c) uterine cervix dysplasia and carcinoma in stages CIN-1, CIN-2 and CIN-3; d) early stages of prostate cancer of TNM classification T1 including T1a as well as T1b or equivalent classification; e) all non-malignant (benign) tumours and polycythaemia vera; f) all pre-malignant stages, non-invasive tumour stages - the so-called carcinomas in situ and microinvasive findings; g) hyperkeratosis, squamous and basocellular forms of skin cancer.	Discharge report from hospital or a confirmed copy of a report by specialist facility that has determined or confirmed the diagnosis, always stating the date, on which the diagnosis was made; further also photocopies of histological finding together with the number of the preparation. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - oncologist or pathologist based on histological or other investigation that cannot be challenged (falsified) and that confirms a malignant progressive disease.
10%	**Carcinoma in situ**	Is a pre-invasive tumour, i.e. a tumour that has not yet developed the picture of a malignant tumour. The diagnosis must be determined with histology.	Report by specialist physician oncologist, gynaecologist, gastroenterologist, urologist or other specialist physician together with the results of histological tests

		There is no stromal invasion. It must be clear from the documentation that the tumour has been assigned the histopathology numeric code MN 8000-9999/2. The key for the differentiation of carcinoma in situ is the number after the forward slash /2/.	confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.

Part B - Rider for case of severe diseases of adults (CZV1, CZV3 and CZV5)

Benefit in % of sum assured	Name of diagnosis	Description of diagnosis	Obligatorily submitted documents at claim's notification to insurance company + day of claim:
150 %	**Terminal disease**	There are various diseases the course of which is very likely to result in the death of the insured within 12 months. These are, for example, generalized tumour diseases that have escaped the control by treatment, or terminal stages of failure of vitally important organs (heart etc.) where it is not possible to perform transplantation in a specific case, e.g. as a result of systemic damage to the organism. Both diagnosis and prognosis must be determined by a relevant specialist physician (i.e. oncologist, cardiologist and the like). In cases of an oncological diagnosis the attending oncologist must confirm that this is the case of the insured when all available treatment for a malignant disease has been exhausted and only symptomatic and palliative treatment is possible. Analogically, the attending cardiologist must confirm permanent and severe damage to the heart that cannot be treated using an alternative surgical procedure than possibly heart transplantation that, however, is not possible in this specific case. The condition to be met here is that of the severity of the disease that requires permanent medication and monitoring because of persisting clinical complaints corresponding to cardiac failure of NYHA classification III-IV. Ejection fraction of the left ventricle must be less than 25%. The insurance company is entitled to review the health condition of the insured and the submitted documents on the health condition through the mediation of a specialist who shall be designated by the insurance company.	Report by attending physician - oncologist, cardiologist or other specialists that confirms the diagnosis, the stage, treatment and prognosis of the disease. Day of claim's rise is the day, as of which the oncologist or another specialist has confirmed the terminal stage of the disease that corresponds to the provided description.
100 %	**Myocardial infarction**	It is the death of part of the myocardium (heart muscle) that is caused by interrupted vascular supply to the relevant region. The diagnosis of myocardial infarction must be confirmed by the fulfilment of the following criteria: a) typical course of chest pain; b) fresh changes in the ECG that demonstrate the infarction; c) characteristic increase of specific enzymes or positivity of relevant biochemistry tests.	Discharge report from hospital or specialist facility that has determined the diagnosis or confirmed the diagnosis, always stating the date, on which the diagnosis was made. Day of claim's rise is the day, as of which the diagnosis of acute myocardial infarction was made by the specialist physician – cardiologist.
100 %	**By-pass surgery of coronary arteries**	It is a surgical treatment of a stenosis or occlusion of one or more coronary arteries with the transplantation of bypass. Occlusion or significant stenosis must be documented with angiography. The surgery must be recommended by a cardiologist as a vitally necessary procedure. The surgery must be carried out within the territory of the Czech Republic. An operation that has been conducted abroad must be approved by the insurance company in writing in advance. In cases where this condition is not met the insurance company is not obliged to provide the benefit payment. **The right to benefit payment does not arise in the case of:** an angioplasty and other intra-arterial technique based on catheterisation or laser procedures.	Comprehensive report from specialist facility where the by-pass surgery was carried out, always stating the date of surgery. Day of claim's rise is the day when the surgery was performed.
100 %	**Surgery - aortic valve replacement**	It is a surgical replacement of one or more cardiac valves with an artificial valve. The defects of a valve or valves must be severe enough so that it is impossible to correct them using an intracardiac catheterisation technique. The replacement must be	Comprehensive report from the specialist facility where the replacement was carried out, always stating the date of the surgery. Day of claim's rise is the day when the surgery was performed.

		carried out based on a referral by a cardiologist. The surgery must be carried out within the territory of the Czech Republic. Conduction of the surgery abroad must be approved by the insurance company in writing in advance. In cases where this condition is not satisfied the insurance company is not obliged to provide the benefit payment.	
100 %	**Aortic surgery**	It is a surgical procedure on the aorta carried out as a result of its dissection, the formation of an aneurysm or its stenosis. The surgery must be carried out based on a recommendation of a cardiologist. The surgery must be performed within the territory of the Czech Republic. Surgery that has been conducted abroad must be approved by the insurance company in advance and this must be done in writing. In cases where this condition is not met, the insurance company is not obliged to provide the benefit payment. **The right to benefit payment does not arise if the surgery is:** surgery on the aortic branches or involves by-passes originating in the aorta and supplying blood to the peripheral bloodstream and surgical solution using stent grafts.	Comprehensive report from a specialist facility where the surgery was carried out, always stating the date of the surgery. Day of claim's rise is the day when the surgery was carried out.
100 %	**Dilated cardiomyopathy - cardiac failure**	Cardiomyopathy (a disease of the heart muscle - myocardium) in the sense of this insurance is to be understood as dilated cardiomyopathy, i.e. usually as post-inflammatory damage do the myocardium. The diagnosis must be confirmed by a cardiologist based on clinically significant symptoms (that is, according to NYHA III-IV classification of cardiac failure), ECG, echocardiography (LVEF must be below 25%), catheterisation investigation, possibly also supplemented by cardiac biopsy **The right to benefit payment does not arise in cases of:** other cardiomyopathies, i.e. hypertrophic, restrictive, genetically caused and caused by toxic influences (alcoholic cardiomyopathy) or in patients with concurrent HIV infection.	Report from specialist facility that confirms the stated diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
100 %	**Stroke**	It is any accidental cerebrovascular event caused by bleeding into the cerebral tissue or by cerebral ischaemia resulting in the development of permanent neurological findings that can be objectively determined. The diagnosis must be supported by corresponding changes in the CT (computed tomography) or MRI (magnetic resonance imaging). **The right to benefit payment does not arise if:** the stroke has been caused by injury and in cases of minor vascular cerebral events due to short-term ischaemia of certain cerebral regions that manifest as transitory cerebral disturbances and that resolve rapidly. (TIA - transitory ischaemic attacks)	Results of neurologist examination (CT angiography or MRI); discharge report from hospital or report by a specialist facility that determined or confirmed the diagnosis, always stating the date when the diagnosis was determined; report confirming the persistence of neurological findings at 3 to 6 months after the event has taken place. Day of claim's rise is the day, as of which the described diagnosis was determined by the specialist physician.
100 %	**Primary pulmonary hypertension**	It is hypertrophy or dilation of the right cardiac ventricle (cor pulmonale) with mean pulmonary artery pressure higher than 25mm Hg that results in permanent deterioration of physical activity capacity corresponding to the NYHA class IV (classification of cardiac damage). The diagnosis must be determined by the attending cardiologist or pulmonologist with submitted results of cardiac catheterisation.	Report from specialist physician – pulmonologist or cardiologist – confirming the diagnosis. The day of claim's rise is the day, as of which the described diagnosis was determined by relevant specialist physician.
100 %	**Severe respiratory failure**	It is a final stage of pulmonary diseases that results in permanent respiratory failure (i.e. chronic respiratory insufficiency). The diagnosis must be confirmed by specialist physician – pulmonologist. All of the following four criteria must be satisfied simultaneously: a) FEV1 value (as part of spirometry) is permanently lower than 1 litre; b) it is necessary that permanent oxygen therapy is carried out for hypoxemia; c) the partial oxygen pressure (PaO_2) value as part of blood gas analysis is equal to 55 mm Hg or less; d) the patient experiences resting dyspnoea.	Comprehensive report from the specialist workplace that has determined the diagnosis, always stating the date of the diagnosis; including the report describing spirometry investigation, blood gas analysis and confirmation that oxygen therapy is carried out. The day of claim's rise is the day, as of which the diagnosis of severe respiratory insufficiency has been made by physician – pulmonologist.
100 %	**Liver failure**	It is a final stage of liver disease that causes uncontrolled ascites, permanent jaundice, the	Report from specialist physician, i.e. internist or hepatologist, confirming this diagnosis.

		development of oesophageal and gastric varices and hepatic encephalopathy. These stated symptoms must be present simultaneously. The diagnosis must be determined by a specialist physician, hepatologist or internist. **The right to benefit payment does not arise if it is about:** cases of liver failure caused by alcohol or addictive substances abuse.	Day of claim's rise is the day, as of which the diagnosis described above has been determined by the relevant specialist physician.
100 %	**Renal failure requiring dialysis or transplantation**	This is an advanced and irreversible failure of both kidneys such that it requires treatment with artificial kidney that is carried out as part of regular and permanent program of dialysis. The relevant specialist physician must confirm that the treatment with artificial kidney lasted at least 3 months.	Decision about inclusion in permanent dialysis programme; confirmed report from the dialysis centre (nephrology) after 3 months of continued treatment with artificial kidney. Day of claim's rise is the day of inclusion of the insured in permanent dialysis programme by a physician.
100 %	**Aplastic anaemia**	It is a chronic failure of the function of bone marrow leading to the presence of insufficient number of both red and white blood cells as well as of thrombocytes in blood. The disease must satisfy at least one of the following conditions: a) regular administration of blood transfusions for at least three months, b) regular application of immunosuppressive substances for at least three months, c) transplantation of bone marrow or inclusion in the programme of bone marrow transplantation. The diagnosis must be confirmed by haematologist.	Report about the course of the disease from the attending haematologist. Day of claim's rise is the day, as of which the diagnosis of aplastic anaemia was determined by the relevant haematologist.
100 %	**Transplantation of vital organs and bone marrow transplantation**	Is a vitally necessary transplantation of heart, heart and lungs, liver, kidneys, pancreas, bone marrow, where the recipient is the insured person. The transplantation must be based on objective confirmation of the failure of the relevant organ by specialist physicians. The surgery must be performed within the territory of the Czech Republic. Surgery that has been conducted abroad must be approved by the insurance company in advance and this must be done in writing. In cases where this condition is not satisfied the insurance company is not obliged to provide the benefit payment. **The right to benefit payment does not arise in cases where:** other organs, parts of the above stated organs, cellular tissues or the so-called stem cells were transplanted.	Comprehensive report from the specialist workplace where the transplantation was carried out, always stating the date of surgery. Day of claim's rise is the day, on which the surgery was performed.
100 %	**Systemic lupus erythematosus with renal involvement**	It is an autoimmune systemic disorder characterised by the development of autoantibodies against various organs of the patient; morphological classification WHO class III to VI must be confirmed with renal biopsy. Renal involvement must be in the stage of terminal failure of renal functions, i.e. the patient must be included in a dialysis programme.	Report from specialist physician - rheumatologist with results of biopsy investigation confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
100 %	**Multiple sclerosis**	Is a chronic disease of the central nervous system caused by damage of the myelin sheaths of the nerve fibres characterised by myelin loss. It must be such stage of the disease where there the two following conditions are met during the time of validity of this rider: a) there must persist neurologically unquestionable signs of damage to the optic nerves, the brain stem, the spinal cord, coordination or perceptive functions that are confirmed by a neurologist; b) the condition of the insured must be severe, to such extent that he or she has been granted disability degree III exclusively because of this diagnosis.	Discharge report from hospital or a report from the neurology department where a permanent diagnosis has been determined or confirmed, always stating the date, as of which the diagnosis was determined; medical assessment confirming disability; decision on acknowledgement of disability pension of degree III by the Czech Social Security Administration. Day of claim's rise is the day when the insured person was acknowledged disability of degree III because of this disease (based on the decision on granting disability pension of degree III by the Czech Social Security Administration).
100 %	**Amyotrophic lateral sclerosis**	This is a progressive degenerative disease of the motor neurons with the presence of muscle paresis and atrophy resulting in such damage to the insured that he or she is not able to perform at least three activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person.	Report from specialist physician – neurologist with all necessary tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - neurologist.
100 %	**Apallic syndrome**	It is a necrosis (death) of the cerebral cortex without damaged brain stem. This condition must be	Report from specialist physician – anaesthetist or neurologist confirming this diagnosis.

		confirmed by a specialist physician, neurologist or anaesthetist. The criteria for the diagnosis of apallic syndrome must last and be satisfied for at least 1 month. **The right to benefit payment does not arise in the following cases:** apallic syndromes caused by intoxication with alcohol and consummation of addictive drugs.	Day of claim's rise is the day, as of which the outset (beginning) of the apallic syndrome was determined by the relevant specialist physician.
100 %	**Loss of speech not related to injury**	It is a complete, permanent and irreversible loss of the ability to speak as a result of damage to the vocal cords persisting continuously for at least 12 months. The diagnosis must confirm the damage to the vocal cords causing loss of speech. **The right to benefit payment does not arise when:** the damage is a consequence of mental condition (i.e. all causes related to psychiatric diagnoses) or the case is caused by injury.	Report from specialist physician – neurologist, ENT specialists, or psychiatrist confirming this diagnosis. Day of claim's rise is the day, as of which the permanent loss of speech was determined by the relevant specialist physician.
100 %	**Paralysis of extremities (loss of ability to use the limbs)**	It is a paralysis of all extremities (quadriplegia) lasting at least three months. The diagnosis must be confirmed by a specialist physician, a neurologist or a traumatologist. **The right to benefit payment does not arise in cases of:** partial paralysis, transitory paralysis and paralysis caused by injury.	Report from specialist physician – neurologist or traumatologist confirming this diagnosis. Date of claim's rise is the day, as of which the paralysis started.
100 %	**Blindness not related to injury (both eyes)**	It is a complete and permanent loss of sight in both eyes caused by a disease that developed during the period of duration of this rider. **The right to benefit payment does not arise when:** the blindness was caused by injury.	Medical report from a specialist workplace describing the course of the disease of the eyes that caused permanent bilateral blindness. Day of claim's rise is the day, as of which the permanent blindness was determined by a specialist physician – ophthalmologist
100 %	**Deafness not related to injury (hearing loss in both ears)**	It is a complete bilateral and permanent hearing loss that was caused by a disease that developed/started during the period of duration of this rider. The diagnosis must be confirmed by medical examination that includes audiometry and hearing threshold tests and a report from a specialist physician – an ENT specialist. **The right to benefit payment does not arise when:** the deafness was caused by injury.	Report from hospital, in the case of hospital stay in a specialist workplace (ENT) that has determined the diagnosis; report describing auxiliary investigations of the he hearing apparatus (X-ray, CT, audiogram and other). Day of claim's rise is the date, as of which the permanent deafness has been determined by a specialist physician – an ENT specialist.
100 %	**Cancer**	It is a disease that manifests as the occurrence of malignant tumours with characteristic uncontrolled growth and spread of the tumour cells and their penetration into healthy tissue. These diseases also include leukemias, sarcomas, malignant disorders of the lymphatic system (e.g. Hodgkin's disease), malignant disease of the bone marrow and metastatic forms of skin cancer. **The right to benefit payment does not arise when the diseases involved are:** a) tumour diseases in the presence of HIV infection; b) malignant skin melanomas with stage 1A depth (less than 1 mm, II or III without ulceration) according to the valid classification AJCC from 2002; c) uterine cervix dysplasia and carcinoma in stages CIN-1, CIN-2 and CIN-3; d) early stages of prostate cancer of TNM classification T1 including T1a as well as T1b or equivalent classification; e) all non-malignant (benign) tumours and polycythaemia vera; f) all pre-malignant stages, non-invasive tumour stages - the so-called carcinomas in situ and microinvasive findings; g) hyperkeratosis, squamous and basocellular forms of skin cancer.	Discharge report from hospital or a confirmed copy of a report by the specialist facility that has determined or confirmed the diagnosis, always stating the date on which the diagnosis was made; further photocopies of histological finding together with the number of the preparation. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - oncologist or pathologist based on histological or other investigation that cannot be challenged and that confirm the presence of malignant progressive disease.
100 %	**Non-malignant brain tumour**	These are non-malignant tumours of the brain, the meninges, and medulla oblongata that pose danger to the life of the insured through compression of the surrounding tissue, and not as a result of their malignant nature. Such tumour must be confirmed through neurologist investigation and it must be recommended for neuro-surgical procedure by a neurologist. In those cases that are evaluated as inoperable, the neurologist examination must demonstrate permanent neurological consequences for the insured.	Comprehensive report from the specialist facility that has established or confirmed the diagnosis, always stating the date when the diagnosis was established, including the results of investigations that demonstrate the severity of the non-malignant tumour (CT, MRI, X-ray and other investigations). Day of claim's rise is the day, as of which the diagnosis of a severe non-malignant tumour was established by a specialist physician – neurologist.

		The right to benefit payment does not arise in the following cases: simple cysts, granulomas, vascular malformation, haematomas, pituitary and spine tumours.	
100 %	**AIDS/HIV a) as a result of blood transfusion or b) or as a profession-related disease in health care workers**	This is an advanced AIDS disease or the demonstrated presence of infection with any HIV virus if the insured has been infected : a) through the transfusion of blood containing infected blood or blood products administered in an officially registered facility within the territory of the Czech Republic during the period of the rider's duration. It is necessary to demonstrate the formation of antibodies corresponding to an HIV infection within 6 months of the administration of a transfusion; b) with an injection needle as a result of injury sustained as part of engagement in normal working duties of physicians, nurses, health-care workers, firemen/firefighters, and rescue team members. It is also necessary that the insured provide the results of a negative test for HIV antibodies that has been carried out immediately after the injury. The formation of antibodies corresponding to HIV infection must be demonstrated within 6 months of the injury. Insurance coverage does not include persons with haemophilia.	For cases under a) a statement from an officially registered workplace in the Czech Republic that has administered the infected blood or blood derivative; further a positive result of investigation of antibodies against HIV within 6 months after the administration of the preparation. For cases under b) negative results of a test for HIV antibodies that was carried out within 7 days of the injury; Day of claim's rise is the day when the transfer of or infection with HIV occurred.
30 %	**Status post angioplasty (PCI)**	This is an invasive (catheterisation) treatment of a process that narrows the lumen of coronary arteries, most commonly caused by atherosclerosis. The coronary arteries can be made patent with balloon angioplasty, with possible introduction of a stent, or with other techniques, e.g. using a cutter, laser instrument etc. It must be confirmed by a cardiologist report, including the result of coronarography investigation. The repost must document that the procedure in question was carried out on at least one vessel with a stenosis (narrowing) of at least 60%.	Report from a specialist physician - cardiologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was established by a specialist physician - cardiologist.
30 %	**Pulmonary fibrosis**	It is a disease of unknown origin affecting the pulmonary insterstitium. The diagnosis must be confirmed with biopsy and a report from the relevant specialist - pulmonologist.	Report from specialist physician - pulmonologist with the results of bioptic investigation confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was established by a specialist physician - pulmonologist.
30 %	**Alzheimer's disease**	It is a neurodegenerative disease due to specific degenerative changes in the cerebral tissue manifesting as dementia of the affected person, with the duration of treatment of at least three months. Affected individuals must exhibit significant reduction of cognitive functions, declining memory, perception, intellect, speech, orientation in time and space to such a degree that the affection makes it impossible that they pursue their profession and manage the activities of daily life in contact with their environment. The diagnosis must be established before the age of 65 years of the insured and documented by the results of conducted diagnostic investigations. **The right to benefit payment does not arise in cases of:** alcoholic dementia.	Report from attending physician - neurologist including specialist findings, such as MRI, psychological tests etc., and confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been established by a specialist physician - neurologist.
30 %	**Severe dementia**	It is a degenerative damage to the brain manifesting as dementia in the insured. This must be a significant reduction of the cognitive functions, memory, perception, intellect, or mental orientation of the affected person, i.e. of such degree that it prevents them to pursue their profession and results in the loss of their ability to manage the activities of daily life. It is required that the condition be confirmed as irreversible, meaning that it is a condition that does not respond with improvement to systematic medical treatment lasting at least 3 months. The diagnosis must be established before 65 years of age of the insured and must be confirmed by a neurologist and be supported by relevant tests of	Report from specialist physician - neurologist with the results of relevant tests (psychometric tests, CT, MRI) confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was established by the specialist physician - neurologist.

		cognitive functions and other investigations, such as MRI or CT. **The right to benefit payment does not arise if the condition is:** alcohol-related dementia, or in psychiatric disorders with similar manifestations.	
30 %	**Epilepsy**	For the purposes of this rider, this diagnosis must only be the form of epilepsy of Jacksonian seizures that is an unquestionable and severe form manifesting as typical symptoms such as unconsciousness with uncontrolled fall, motor manifestations of the characteristic convulsions, often with the complications of the type of biting of the tongue and incontinence. The diagnosis must be confirmed by the report from a specialist physician, neurologist. **The right to benefit payment does not arise in the following cases:** cases of coincidence of this disease with toxicomania and alcohol abuse.	Report from specialist physician - neurologist confirming this diagnosis of epilepsy of the Jacksonian type. Day of claim's rise is the day, as of which the described diagnosis was established by the specialist physician - neurologist.
30 %	**Muscle dystrophy/atrophy**	A group of degenerative diseases of the muscles characterised by painful and weak (atrophic) muscles, as a result of damage sustained by the insured such that he or she is unable to perform at least three activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person.	Report from specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the specialist physician - neurologist.
30 %	**Parkinson's disease**	It is a permanent deterioration of motor functions associated with tremor, muscle rigidity, deteriorated movement and bodily instability caused by degenerative brain disease that has been treated for at least three months. The disease must result in severe complaints regarding locomotion, and in essential effects on the life of the insured, and also in permanent inability to manage the activities of daily life. The diagnosis must be determined by a specialist physician - neurologist before the age of 65 years of the insured, and documented with the results of diagnostic examinations. **The right to benefit payment does not arise if:** the Parkinson's disease was caused by drug overdose or consummation of addictive drugs or by injury.	Report by a specialist physician - neurologist with appropriate laboratory investigations of the brain (CT, EEG) confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - neurologist.
30 %	**Coma**	This is a state of permanent deep unconsciousness of a patient who does not react to external stimuli and inner needs. The patient survives only as a result of the use of instruments supporting vital functions, such as controlled ventilation. Duration of the coma must be at least 96 hours. It is necessary to provide a neurologist report confirming the presence of residual neurologist finding. The coma must be documented by a report from the respective department of anaesthesiology and resuscitation.	Report from specialist physician - anaesthetist or neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the onset of the coma has been determined by the relevant specialist physician.
30 %	**Paralysis of two extremities simultaneously not related to injury**	It is a paralysis of at least two extremities (paraplegia, hemiplegia) lasting at least three months. **The right to benefit payment does not arise if:** the paralysis affects only one extremity (monoplegia), is only partial (paresis), a transitory paralysis, or is related to injury.	Report from a specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the paralysis occurred.
30 %	**Amputation of upper and lower extremities, not related to injury**	It is an amputation of at least two extremities as a result of a disease that developed during the period of duration of this raider, and must concern the hands and/or feet at least in the wrist joint and/or in the ankle joint. The diagnosis must be confirmed by the attending physician. **The right to benefit payment does not arise if:** the amputation of upper and lower extremities occurs as a result of injury.	Report from a specialist physician - a surgeon with precise description of the causes, course and level of the amputation. Day of claim's rise is the day, as of which the amputation of the second extremity was carried out.
30 %	**Rheumatoid arthritis**	The concept of the stated diagnosis for the purposes of this rider is to be understood as an autoimmune systemic disease affecting preferentially the small joints. The disease must be confirmed, without any doubt, by the relevant specialist physician (rheumatologist). The diagnosis must be documented by a rheumatologist report	Report form a specialist physician - rheumatologist with the results of biopsy investigation confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the specialist physician - rheumatologist.

		documenting the presence of characteristic complaints, the determination of involvement of other organs (e.g. heart and lungs) and the positivity of laboratory investigations, including the values of inflammatory markers (CRP, erythrocyte sedimentation rate) and the levels of specific antibodies (i.e. RF - rheumatoid factor). The diagnosis must be confirmed by rheumatologist.	
30 %	**Bechterew's disease**	This is an inflammatory disease of the spine with the demonstration of positive HLA-B 27 antigen(ankylosing spondylitis of the spine). The disease in the stage 4 to 5 must be documented with the results of the investigations with CT (computed tomography) or MRI (magnetic resonance imaging) of the spine depicting fused vertebral bodies that are changed through inflammation (bamboo spine); it is necessary that marked clinical complaints are present at the same tine (pain associated with movement and restriction of respiratory mechanics).	Report from specialist physician - rheumatologist together with relevant results of MRI, X-ray and CT investigations. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
30 %	**Rheumatic fever with cardiac complications**	Rheumatic fever in the sense of this rider is an autoimmune reaction to the antibodies that are formed against the bacteria of beta-haemolytic streptococcus, with confirmed complications as a result of cardiac damage (pericardium, epicardium, myocardium, endocardium including the valves) with clinical symptoms of functionally sever cardiac failure assessed according to the NYHA classification class II–IV. The diagnosis must be documented by a medical report from a specialist workplace (internal medicine, cardiology, rheumatology) including echocardiography.	Report from specialist physician - rheumatologist, cardiologist, or internal medicine specialist with echocardiography confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30 %	**Polyarteritis nodosa**	It is a systemic disease that has the nature of vasculitis affecting multiple organs. It is necessary to document involvement of at least two of the following organ systems simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and specialist physician - rheumatologist based on biopsy investigation.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
30 %	**Wegener's granulomatous vasculitis**	It is a systemic disease that has the nature of vasculitis affecting multiple organs simultaneously. It is necessary to document the involvement of at least two of the following organ systems simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist based on biopsy investigation.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
30 %	**Churg-Strauss syndrome - polyarteritis with pulmonary involvement**	It is a systemic disease in the form of vasculitis affecting multiple organs. It must be documented that at least two of the following organ systems are affected simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist or pulmonologist.	Report from specialist physician - rheumatologist or pulmonologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the date, as of which the described diagnosis was determined by the relevant specialist physician.
30 %	**Kawasaki vasculitis**	It is a systemic disease in the form of vasculitis affecting multiple organs. It must be documented that at least two of the following organ systems are affected simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the date, as of which the described diagnosis was determined by the relevant specialist physician - rheumatologist.
30 %	**Takayasu's vasculitis**	It is a systemic disease in the form of vasculitis affecting multiple organs. It must be documented that at least two of the following organ systems are affected simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - rheumatologist.
30 %	**Systemic progressive scleroderma and CREST syndrome**	It is a systemic disease of the connective tissue caused by diffuse fibrosis of the skin, vessels and inner organs. The diagnosis must be documented by biopsy and serology investigation and at least one of the following organs must be affected: heart, lungs or kidneys. The diagnosis must be confirmed by	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - rheumatologist.

		rheumatologist. **The right to benefit payment does not arise if:** the patient has localised scleroderma (linear or morphoea), eosinophilic fasciitis.	
30 %	**Crohn's disease**	It is a serious disease of the intestines of unclear cause. The diagnosis must be determined by a specialist gastroenterology investigation based on the results of documented colonoscopy, histology and laboratory findings.	Report from specialist physician - gastroenterologist and appropriate laboratory, colonoscopy and histology investigations confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by specialist physician - gastroenterologist.
30%	**Encephalitis - Creutzfeldt-Jakob**	Creutzfeldt-Jakob disease is defined as a disease that causes permanent and irreversible damage to the brain tissue as a result of infection. It is always necessary to provide medical confirmation of Creutzfeldt-Jakob disease. The diagnosis must be determined by a specialist physician from a neurology facility within the territory of the Czech Republic.	Report from a specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - neurologist.
30%	**Tick-borne encephalitis**	This is an inflammation of the brain tissue caused by a virus infection that results in permanent damage to the insured such that he or she is not able to perform at least three activities of daily living, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	Report from a specialist physician - infectologist or neurologist with laboratory results including the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30%	**Encephalitis – Poliomyelitis (infantile cerebral palsy)**	It is an inflammation of the cerebral tissue caused by the poliovirus. It results in the development of a damage to the insured such that he or she is unable to perform at least three of common activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician.
30%	**Japanese encephalitis**	It is an inflammation of the brain tissue caused by demonstrated viral infection. The diagnosis must be confirmed by a special physician - infectologist or neurologist based on the results of laboratory investigations that include lumbar puncture.	Report from specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician.
30%	**Encephalopathy -Reye syndrome**	It is a viral infection (caused by influenza or herpetic viruses) affecting especially the liver and the cerebral tissues, usually in association with the use of acetylsalicylic acid. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations that include lumbar puncture.	Report from specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis was determined by the relevant specialist physician.
30%	**Encephalitis caused by viruses, bacteria**	It is an inflammation of the cerebral tissue caused by viral or bacterial infection that results in such damage to the insured that he or she is unable to perform at least three common activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician.
30%	**Meningitis caused by viruses, bacteria**	It is an inflammation of the membranes covering the brain and of the brain caused by viral or bacterial infection. The diagnosis must be documented by a report from the relevant infectologist or neurologist and supported by positive findings of the results of	Report from specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the date, as of which this diagnosis has been determined by the relevant

		investigation of cerebrospinal fluid (obtained by lumbar puncture) and other findings needed to confirm this disease with necessary laboratory results and tests including serology).	specialist physician.
30%	**Meningoencephalitis caused by viruses, bacteria**	It is an inflammation of the membranes covering the brain and the brain caused by viral or bacterial infection. The diagnosis must be documented by a report from the relevant infectologist or neurologist and supported by positive findings of the results of investigation of cerebrospinal fluid (obtained by lumbar puncture) and other findings needed to confirm this disease with necessary laboratory results and tests including serology).	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the date, as of which the described diagnosis was determined by the relevant specialist physician.
30%	**Fulminant hepatitis**	It is a massive necrosis of the liver tissue in the course of acute viral hepatitis that results in the development of liver failure characterised by the presence of jaundice, rapid reduction of the size of the liver, rapid deterioration of liver function tests, and the development of hepatic encephalopathy within 1 months of the onset of complaints. The diagnosis must be confirmed by a report from a specialist physician - hepatologist or infectologist.	Report from specialist physician - hepatologist or infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30%	**Hepatitis C caused by hepatitis C virus**	This diagnosis must be documented by laboratory (serology) tests that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist.	Report from specialist physician - hepatologist or infectologist with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30%	**Hepatitis D caused by hepatitis D virus**	This diagnosis must be documented by laboratory (serology) tests that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist.	Report from specialist physician - hepatologist or infectologist with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30%	**Hepatitis E caused by hepatitis E virus**	This diagnosis must be documented by laboratory (serology) tests that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist.	Report from specialist physician - hepatologist or infectologist with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30%	**Rabies (Encephalitis)**	It is an inflammation of nerves and brain caused by the rabies virus. The diagnosis must be confirmed by an infectologist or neurologist.	Report from specialist physician - infectologist or neurologist with the results of serology tests including lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
10%	**Carcinoma in situ**	Is a pre-invasive tumour, i.e. a tumour that has not yet developed the picture of a malignant tumour. The diagnosis must be determined with histology. There is no stromal invasion. It must be clear from the documentation that the tumour has been assigned the histopathology numeric code MN 8000-9999/2. The key for the differentiation of carcinoma in situ is the number after the forward slash /2/.	Report by specialist physician oncologist, gynaecologist, gastroenterologist, urologist or other specialist physician together with the results of histological tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
10%	**Lyme disease (Lyme borreliosis)**	Lyme borreliosis in the sense of this rider is to be understood as the determination of diagnosis of the disease in stage II and III of the disease by laboratory testing and confirmed by the relevant specialist workplace – neurology or infectious diseases department. It must be documented by the presence of clinical symptoms, serology investigation of blood, and possibly also, according to location of the damage, by the investigation of the cerebrospinal fluid or the fluid obtained by puncture from a joint. The diagnosis must be documented by a medical report from a specialised workplace.	Report from specialist physician - infectologist or neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
10%	**Tuberculosis**	Tuberculosis in the sense of this disease is to be understood as an infection caused by	Report from specialist physician - infectologit, respirologist, or ftiseologist confirming this diagnosis.

		Mycobacterium tuberculosis (Koch bacillus) that was acquired by contagion from an infected person or through ingestion of a contaminated food (milk …). The diagnosis must be documented by medical report from a specialised workplace (infectious diseases, a specialist clinic according to the specific affected organ – lungs, kidneys, bones, meninges…) through laboratory culture or detection by microscope of the Koch bacillus. **The right to benefit payment does not arise if:-** the insured has not received proper/regular vaccination according to the valid vaccination calendar, and in cases of addictive substances abuse, and of diagnosed HIV positivity.	Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
10%	**Tetanus**	It is an infectious disease caused by the bacterium Clostridium tetani. It must be the most severe form of the disease that necessitates admission to hospital. The diagnosis must be documented with the demonstration of the presence of the bacterium Clostridium tetani, and it is also necessary to determine the degree of severity 2 or 3 according to the classification according to Eyrich, and/or a severe disease with tetanus according to Garnier. The day of determination of the diagnosis is the date, as of which the described diagnosis was established by the relevant specialist physician.	Confirmed copy of a report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Abdominal typhus (typhoid fever)**	It is an infectious disease caused by the bacterium Salmonella typhi that has been acquired through the ingestion of contaminated foods or fluids, possibly also through contact with a carrier of the bacterium. It must be the more severe form of the disease accompanied by high fever, diarrhoea and complications (e.g. bleeding into the intestines, peritonitis, involvement of the bone marrow), all of which are described in the medical report. The diagnosis must be documented through demonstration of the infectious agent through microbiological investigation. **The right to benefit payment does not arise if:** the disease is a Paratyphoid A, B, C, or the affected person is a carrier.	Confirmed copy of the report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Cholera**	It is a disease manifesting with diarrhoea leading to dehydration caused by the bacterium Vibrio cholerae. The diagnosis must be confirmed by an infectologist based on the clinical course of the disease, and must be demonstrated with laboratory investigations.	Report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Dengue fever**	It is a febrile disease caused by the dengue virus transmitted by mosquitos. The diagnosis must be confirmed by an infectologist based on the course of the disease and must be demonstrated with laboratory investigations.	Report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Yellow fever**	It is a febrile disease caused by a virus from the Flaviviridae family. The diagnosis must be confirmed by the infectologist based on the course of the disease and must be demonstrated with laboratory investigations.	Report from a specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Schistosomiasis**	It is a disease caused by various kinds of flatworms (it was formerly known as bilharziosis). The diagnosis must be confirmed by an infectologist based on the course of the disease and must be demonstrated with laboratory investigations.	Report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.
10%	**Malaria**	It is a parasitic disease of the blood caused by protozoans of the genus of Plasmodiae. The diagnosis must be confirmed by an infectologist based on the course of the disease and laboratory investigations.	Report from specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - infectologist.

Special insurance conditions for insurance of the type
RIDER FOR CASE OF CANCER IN ADULTS CZR5
RIDER FOR CASE OF SEVERE DISEASES OF ADULTS CZV5

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of cancer in adults CZR5 and the rider for case of severe diseases of adults CZV5 (hereinafter only "SPC CZR5/CZV5") create an integral part of the contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CZR5/CZV5 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CZR5/CZV5.
3. These riders may be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is diagnosis identification of some of the severe diseases or undergoing some of the surgeries (specified in the Supplement in both cases), however, this only under the condition that this event occurred at the insured person only after expiry of the waiting period of 6 months from the day of this rider's start and at the same time:**
   a) At the rider for case of cancer in adults **CZR5 the insurance coverage concerns only the disease cancer described in Part A of the Supplement**,
   b) At the rider for case of severe diseases of adults **CZV5 the insurance coverage concerns all severe diseases or surgeries described in Part B of the Supplement**.

   It is described in the Supplement, which day is considered as the day of the insured event's rise at individual severe diseases/surgeries.
2. The sum assured is linearly decreasing, therefore it is decreased by 1/n of the arranged sum assured as of each anniversary where "n" represents the arranged duration of cover in years. If there is a change in this rider on the basis of the policyholder's request (change in the sum assured or in the duration of cover), the sum assured is decreased by 1/n of the newly arranged sum assured as of each anniversary where "n" represents the newly arranged duration of cover rounded to whole years upwards, rounded to whole thousands of Czech crowns upwards.
3. **In case of an insured event the insurance company will pay the benefit to the beneficiary in the amount set as product of the topically valid sum assured and the percentage value for individual diagnoses mentioned in the Supplement.**
4. **In case that the paid benefit is lower than 100 % of the topically valid sum assured, the rider does not lapse by the insured event and the insurance company can pay also for other insured events up to the limit of benefit payment, which is the summary of percentage points on the level of 100 % or 150 % when applying the diagnosis of terminal disease, and this regardless of the amount of the sum assured that is topically valid at the time of individual insured events. An example of benefit payment calculation is mentioned in the Supplement to these SPC CZR5/CZV5.**
5. **If the beneficiary has already received a benefit payment from this rider according to the previous paragraphs, subsequent changes in this rider are excluded (this is also valid for exchange of this rider for another one for case of cancer in adults or serious diseases).**
6. **If a so-called terminal disease** (i.e. relevant severe disease in terminal stage as specified in the Supplement to the variants of this rider) **is reported as an insured event, the insurance company reserves the right to examine the insured person's health status or the submitted documents about the insured person's health status and to pay only 100 % of the sum assured for this rider according to standard diagnosis of the given disease in cases when the doctor appointed by the insurance company does not confirm existence of terminal disease in the sense of the definition mentioned in the Supplement.**
7. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status and he/she is not even able to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium at the rider for case of cancer in adults CZR5 and at the rider for case of severe diseases of adults CZV5 is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges for the whole duration of cover in dependence on the age of the insured person as of the rider' start and on the arranged duration of cover; therefore fixed premium rates are arranged for these riders. Only 1 % of premium determined according to the previous sentence is paid during the last 3 years of the rider's duration.
3. Premium is adjusted in case of a change in the insurance on the basis of the policyholder's request according to the new sum assured.
4. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); and (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 5 of these SPC CZR5/CZV5.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in a few exceptional cases that are specified in the Supplement at the diagnoses' description of some severe diseases/surgeries.**
2. **The right to benefit payment also does not arise if the severe disease or surgery occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by**

unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

d) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**

e) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**

f) **Professional operation of a sport by the insured person.**

3. **If an insured event occurs within the period of 6 months from the day when the sum assured of this rider has been increased on the basis of the policyholder's request, the insurance company will decrease benefit payment to the lowest sum assured valid for the last 6 months before the day of this insured event's rise.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. **If the summary of percentage points corresponding to diagnoses mentioned in the Supplement, for which benefit has been paid within this rider, achieves the limit of 100 %, or 150 % when applying the diagnosis of terminal disease, the rider lapses as of the day of the insured event's rise, by which this occurs.**
4. **The rider lapses from the start and the insurance company will return the entire premium paid for this rider to the policyholder if the day of the insured event's rise occurs before expiry of the arranged waiting period of 6 months from the start of this rider.**
5. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally), and this as of the day of the main coverage anniversary.
6. Other ways of this rider's lapse are set by the relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. It is not possible to contractually change the amount of the sum assured or to shorten the duration of cover during the last 5 years of the rider's duration, then it is even not possible to prolong the duration of cover during the last 3 years of this rider's duration.
2. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability and this by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
4. If a period is set for a certain act in these SPC CZR5/CZV5 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
5. **The insurance company has the right to perform an adequate change in these SPC CZR5/CZV5 and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CZR5/CZV5 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CZR5/CZV5 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CZR5/CZV5 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CZR5/CZV5 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Insurance year

Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Supplement

Supplement to these SPC CZR1/CZR3 and CZV1/CZV3 and SPC CZR5/CZV5 containing specification of diagnoses of all severe diseases/surgeries that are covered by this rider including mentioning possible exceptions from benefit payment, decisive day, which is considered as the day of the insured event's rise, percentage value of benefit payment in relation to the arranged sum assured and documents that are obligatorily submitted to the insurance company at the claim's notification;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Example

Arranged sum assured	1,000,000 CZK
Arranged duration of cover (“n“)	10 years
Decrease in sum assured	annually by 1/n of the arranged sum assured
1st insured event	diagnosis with 30 % benefit in the 2nd insurance year
2nd insured event	diagnosis with 10 % benefit in the 4th insurance year
3rd insured event	diagnosis with 100 % benefit in the 8th insurance year
Limit for benefit payment	the maximum summary of percentages of benefit payments for all insured events is **100 %**, or 150 % in case of terminal disease regardless of the topical amount of the sum assured

Decrease in sum assured	
Insurance year	Topically valid sum assured
1	1 000 000 CZK
2	900 000 CZK
3	800 000 CZK
4	700 000 CZK
5	600 000 CZK
6	500 000 CZK
7	400 000 CZK
8	300 000 CZK
9	200 000 CZK
10	100 000 CZK

Calculation of the benefit payment amount		
Insured event	Calculation (percentage of benefit x topically valid sum assured)	Amount of paid benefit
1.	30% x 900 000	270 000 CZK
2.	10% x 700 000	70 000 CZK
3.	**60%*** x 300 000	180 000 CZK

The limit for benefit payment is achieved already after the 3rd insured event and the rider lapses.

*Due to the fact that the summary of benefit payment percentages for all insured events has exceeded 100 % by the 3rd insured event (the summary would be 140 %), the percentage for the last insured event is decreased to the threshold value

Special insurance conditions for insurance of the type RIDER FOR CASE OF SEVERE DISEASES IN CHILDREN CZV2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for case of severe diseases in children CZV2 (hereinafter only "SPC CZV2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CZV2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CZV2.
3. This rider can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider, what benefit payment am I entitled to in case of an insured event?

1. **An insured event within this rider is diagnosis identification of some of the severe diseases specified in the Supplement or undergoing of some of the surgeries specified in the Supplement, however, this only under the condition that this event occurred at the insured person only after expiry of the waiting period of 6 months from the day of this rider's start.** It is described in the Supplement, which day is considered as the day of insured event's rise at individual severe diseases/surgeries.
2. In case of an insured event the insurance company will pay the benefit to the beneficiary in the amount of the arranged sum assured or a part thereof and this in dependence on the type of severe disease/underwent surgery that is subject of the given insured event. Particular level of benefit payment for individual diagnoses or percentage value of benefit payment in relation to the arranged sum assured is mentioned in the Supplement.
3. **If the insured event** when the right to benefit payment arose to the insured person, **is diagnosis identification of a severe disease or undergoing of a surgery where 100 % of the sum assured is arranged for payment in the Supplement, the insurance company will pay a single bonus on the level of 20 % from the sum assured arranged at the start of this rider along with the benefit** that serves as contribution to necessary care for (nursing of) the insured child.
4. **If the level of paid benefit achieves less than 100 % of the sum assured, i.e. 10 % or 30 % according to certain diagnoses specified in the Supplement, the rider does not lapse by such an insured event. The original sum assured will be decreased by the value of the paid benefit after benefit payment realisation to the topical/available sum assured, and this with effect as of the day of the insured event. Also the amount of regular premium will be decreased in a corresponding way as of the same day in compliance with Art. 3 paragraph 3 of these SPC CZV2. The number of insured events according to this paragraph is limited only by the value of the originally arranged sum assured to this rider** (on the maximum level of 100 %). Therefore if the topical/available sum assured does not achieve the relevant amount of benefit to the severe disease/underwent surgery in question with regard to previous benefit payments, the insurance company will decrease the payment of such last benefit in a corresponding way. **So it is not possible to pay more than 100 % of the originally arranged sum assured to this rider in summary whereas the right to payment of the bonus according to paragraph 3 of this Article is not affected by this procedure that means the bonus will be paid in full amount under conditions mentioned in the quoted provision also in case that benefit payment will be decreased due to the reason described in this paragraph.**
5. **If the beneficiary has already received a partial benefit payment from this rider according to the previous paragraph, subsequent changes in this rider are excluded.**
6. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. The insured event is reported by the insured person or by his/her legal representative.

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the sum assured for this rider and the premium rate set in the tariff of charges.
3. Premium rates mentioned in the tariff of charges for this rider were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); and (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine leading to increase in the ability to diagnose and heal the diseases, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 4. of these SPC CZV2.

Article 4 - For which period do I arrange the rider?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in a few exceptional cases that are specified in the Supplement at the diagnoses' description of some severe diseases/surgeries.**
2. **The right to benefit payment also does not arise if the severe disease or surgery occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   d) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   e) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**
3. **The right to benefit payment also does not arise if the day of the insured event's rise occurs before expiry of the waiting period of 6 months from the day of this rider's start.**
4. **If an insured event occurs within the period of 6 months from the day when the sum assured of this rider has been increased on the basis of the policyholder's request, the insurance company will decrease benefit payment to the lowest sum assured valid for the last 6 months before the day of this insured event's rise.**
5. **Other exclusions from benefit payment are set by the relevant provisions of GTC.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.

2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. **If the level of paid benefit achieves 100 % of the sum assured, the rider lapses as of the day of the given insured event's rise.**
4. **The rider lapses from the start and the insurance company will return the entire premium paid for this rider to the policyholder if the day of the insured event's rise occurs before expiry of the arranged waiting period of 6 months from the start of this rider.**
5. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
6. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider himself/herself or through his/her legal representative (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability and this by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
3. If a period is set for a certain act in these SPC CZV2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. The insurance company has the right to perform an adequate change in these SPC CZV2 and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CZV2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company. The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CZV2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CZV2 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CZV2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims does not arise to the insurance company;

Insurance year

Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on periods among the dates of main coverage anniversaries following one after another;

Supplement

Supplement to these SPC CZV2 containing specification of diagnoses of all severe diseases/surgeries that are covered by this rider including mentioning possible exceptions from benefit payment, decisive day, which is considered as the day of the insured event's rise, percentage value of benefit payment in relation to the arranged sum assured and documents that are obligatorily submitted to the insurance company at the claim's notification;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF THE RIDER OF SEVERE DISEASES IN CHILDREN CZV2

Benefit in % of sum assured (SA) (in children)	Name of diagnosis	Description of diagnosis	Obligatorily submitted documents at claim's notification to insurance company + day of claim's rise:
100% SA + 20% bonus	**Myocardial infarction**	It is the death of part of the myocardium (heart muscle) that is caused by interrupted vascular supply to the relevant region. The diagnosis of myocardial infarction must be confirmed by the fulfilment of both of the following criteria: a) fresh changes in the ECG that demonstrate the infarction; b) characteristic increase of specific enzymes or positivity of relevant biochemistry tests.	Discharge report from hospital or specialist facility that has determined the diagnosis or confirmed the diagnosis, always stating the date on which the diagnosis was made. Day of claim's rise is the day, as of which the diagnosis of acute myocardial infarction was made by the specialist physician – e.g. a cardiologist.

100% SA + 20% bonus	**Cardiac surgery to correct valvular defects and to solve shunts between cardiac chambers**	It is necessary that cardiac surgery is performed that is indicated by a cardiologist and the purpose of the surgery is to correct valvular defects and to solve shunts between cardiac chambers. The surgery must be carried out within the territory of the Czech Republic. An operation that has been conducted abroad must be approved by the insurance company in writing in advance. In cases where this condition is not met the insurance company is not obliged to provide the benefit payment.	Comprehensive report from the specialist workplace where the replacement was carried out, always stating the date of the surgery. Day of claim is the day, on which the surgery was carried out.
100% SA + 20% bonus	**Dilated cardiomyopathy - cardiac failure**	Cardiomyopathy (a disease of the heart muscle - myocardium) in the sense of this insurance is to be understood as dilated cardiomyopathy, i.e. usually as post-inflammatory damage do the myocardium. The diagnosis must be confirmed by a cardiologist based on clinically significant symptoms (that is, according to NYHA III-IV classification of the cardiac failure), ECG, echocardiography (LVEF must be below 25%), catheterisation investigation, possibly also supplemented by cardiac biopsy **The right to benefit payment does not arise in cases of:** other cardiomyopathies, i.e. hypertrophic, restrictive, genetically caused and caused by toxic influences (alcoholic cardiomyopathy) or in patients with concurrent HIV infection.	Report from the specialist facility that confirms the stated diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
100% SA + 20% bonus	**Aortic surgery**	It is a necessary surgery indicated by a cardiologist that must be carried out within the territory of the Czech Republic. Surgery that has been conducted abroad must be approved by the insurance company in writing in advance.	Comprehensive report from a specialist facility where the surgery was carried out, always stating the date of the surgery. Day of claim's rise is the day when the surgery was carried out.
100% SA + 20% bonus	**Intracranial bleeding (not related to injury)**	It is any intracranial bleeding into the brain, its ventricles or into the meninges. **The right to benefit payment does not arise if:** the intracranial bleeding has been caused by injury.	Results of neurologist investigation (CT, angiography or MRI); discharge report from hospital or a report from the specialist workplace that has determined or confirmed the diagnosis, always stating the date, on which the diagnosis was determined; confirmation of persisting neurological findings at 3 to 6 months after the event of bleeding. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician.
100% SA + 20% bonus	**Cerebral damage caused by insufficient blood supply**	Is any cerebral damage caused by cerebral ischaemia that results in permanent neurological consequences (after-effects).	Results of neurologist investigation (CT, angiography or MRI); discharge report from hospital or a report from the specialist workplace that has determined or confirmed the diagnosis, always stating the date on which the diagnosis was determined; confirmation of persisting neurological findings at 3 to 6 months after the event of bleeding. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician.
100% SA + 20% bonus	**Severe respiratory insufficiency**	It is a final stage of pulmonary diseases that results in permanent respiratory failure (i.e. chronic respiratory insufficiency). The diagnosis must be confirmed by a specialist physician – pulmonologist. All of the following four criteria must be satisfied simultaneously: a) FEV1 value (as part of spirometry) is permanently lower than 50% of the values corresponding to age/expected values; b) it is necessary that permanent oxygen therapy is carried out for hypoxemia; c) the partial oxygen pressure (PaO2) value as part of blood gas analysis is equal to 55 mm Hg or less.	Comprehensive report from the specialist workplace that has determined the diagnosis, always stating the date of the diagnosis; including the report describing the spirometry investigation, blood gas analysis, and confirmation that oxygen therapy is being carried out. The day of claim's rise is the day, as of which the diagnosis of severe respiratory insufficiency has been made by a physician – pulmonologist.
100% SA + 20% bonus	**Severe liver insufficiency**	It is a final stage of liver disease that causes uncontrolled ascites, permanent jaundice, the development of oesophageal and gastric varices and hepatic encephalopathy. These stated symptoms must be present simultaneously. The diagnosis must be determined by a specialist physician, hepatologist or internist. **The right to benefit payment does not arise in:** cases of liver failure caused by alcohol or addictive substances abuse.	Report from a specialist physician, internist or hepatologist, confirming this diagnosis. Day of claim's rise is the day, as of which the diagnosis described above has been determined by the relevant specialist physician.
100% SA + 20% bonus	**Renal failure requiring dialysis or transplantation**	It is an advanced and irreversible failure of both kidneys such that it requires treatment with artificial kidney that is carried out as part of regular and permanent program of dialysis. The relevant specialist physician must confirm that the	Decision about inclusion in a permanent dialysis programme or confirmed report from the dialysis centre (nephrology) after 3 months of continued treatment with artificial kidney. Day of claim's rise is the day when the insured has reached 3 months of dialysis treatment.

		treatment with artificial kidney lasted for at least 3 months.	
100% SA + 20% bonus	**Aplastic anaemia**	It is a chronic failure of the function of bone marrow leading to the presence of insufficient number of both red and white blood cells as well as of thrombocytes in blood. The disease must satisfy at least one of the following conditions: a) regular administration of blood transfusions for at least three months, b) regular application of immunosuppressive substances for at least three months, c) transplantation of bone marrow or inclusion in the programme of bone marrow transplantation. The diagnosis must be confirmed by haematologist.	Report about the course of the disease from the attending haematologist. Day of claim's rise is the day, as of which the diagnosis of aplastic anaemia was determined by the relevant haematologist.
100% Sa + 20% bonus	**Transplantation of vital organs and bone marrow transplantation**	Is a vitally necessary transplantation of heart, heart and lungs, liver, kidneys (that has not yet been indemnified according to other rules – in the setting of failure), pancreas, bone marrow, where the recipient is the insured. The transplantation must be based on objective confirmation of the failure of the relevant organ by relevant specialist physicians. The surgery must be performed within the territory of the Czech Republic. Surgery that has been conducted abroad must be approved by the insurance company in advance and this must be done in writing. In cases where this condition is not satisfied the insurance company is not obliged to provide the benefit payment. **The right to benefit payment does not arise in cases where:** other organs, parts of the above stated organs, cellular tissues or the so-called stem cells were transplanted.	Comprehensive report from the specialist workplace where the transplantation was carried out, always stating the date of surgery. Day of claim's rise is the day, on which the surgery was performed
100% SA + 20% bonus	**Idiopathic pulmonary fibrosis**	It is a disease of unknown origin affecting the pulmonary interstitium. The diagnosis must be confirmed with biopsy and a report from the relevant specialist - pulmonologist.	Report from specialist physician - pulmonologist with the results of bioptic investigation confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was established by a specialist physician - pulmonologist.
100% SA + 20% bonus	**Cystic fibrosis**	It is a multiple-system disorder manifesting with chronic airway disease, exocrine pancreatic insufficiency, high levels of sweat electrolytes, and obstructive azoospermia. The diagnosis must be confirmed by a paediatrician based on molecular genetics investigation, or based on the clinical finding of positivity of the so-called sweat test (levels of chlorides in sweat must exceed the value of 60 mmol/l).	Report from a specialist physician - pulmonologist containing the results of the molecular genetics investigation or the so-called sweat test. Day of claim's rise is the day, as of which the described diagnosis was determine by the specialist physician - pulmonologist.
100% SA + 20% bonus	**Epidermolysis bullosa (butterfly's wings disease)**	It is a serious dermatological disease characterised by rather fragile skin with complicated healing.	The diagnosis must be confirmed by a specialist physician – dermatologist or paediatrician. Day of claim's rise is the day, as of which the described diagnosis has been determined by the specialist physician – dermatologist or a paediatrician.
100% SA + 20% bonus	**Juvenile systemic progressive scleroderma**	It is a systemic disease of the connective tissue caused by diffuse fibrosis of the skin, vessels and inner organs. The diagnosis must be documented by biopsy and serology investigation and at least one of the following organs must be affected: heart, lungs or kidneys. The diagnosis must be confirmed by rheumatologist. **The right to benefit payment does not arise if:** the patient has localised scleroderma (linear or morphoea).	Report from a specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - rheumatologist.
100% SA + 20% bonus	**Multiple sclerosis**	It is a chronic disease of the central nervous system caused by damaged myelin sheaths of the nerve fibres characterised by myelin loss. It must be such stage of the disease where clear signs of neurological damage of the patient persist. The diagnosis must be documented by positive findings in magnetic resonance imaging.	Discharge report from hospital or a report from the neurology workplace that has determined or confirmed the permanent diagnosis, always stating the date on which the diagnosis was determined. Day of claim's rise is the day, on which the diagnosis was determined by a specialist physician – neurologist.
100% SA + 20% bonus	**Amyotrophic lateral sclerosis**	It is a progressive degenerative disease of the motor neurons with the presence of muscle paresis and atrophy resulting in such damage to the insured that he or she is not able to perform at least three activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so that he or she	Report from a specialist physician – neurologist with all necessary tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - neurologist.

		depends on the help of another person.	
100 % SA + 20 % bonus	**Apallic syndrome**	It is a necrosis (death) of the cerebral cortex without damaged brain stem. This condition must be confirmed by a specialist physician, neurologist or anaesthetist. The criteria for the diagnosis of apallic syndrome must last and be satisfied for at least 1 month. **The right to benefit payment does not arise in the following cases:** apallic syndromes caused by intoxication with alcohol and consummation of addictive drugs.	Report from a specialist physician – anaesthetist or neurologist confirming this diagnosis. Day of claim's rise is the day, on which the diagnosis of apallic syndrome of the insured lasted already 1 month.
100% SA + 20% bonus	**Loss of speech not related to injury**	It is a complete, permanent and irreversible loss of the ability to speak as a result of damage to the vocal cords persisting continuously for at least 12 months. The diagnosis must confirm the damage to the vocal cords causing loss of speech. **The right to benefit payment does not arise when:** the damage is a consequence of a mental condition (i.e. all causes related to psychiatric diagnoses), or the case is caused by injury.	Report from a specialist physician – neurologist, ENT specialist, or psychiatrist confirming this diagnosis. Day of claim's rise is the day, as of which the permanent loss of speech was determined by the relevant specialist physician.
100% SA + 20% bonus	**Paralysis of extremities (loss of ability to use the limbs)**	It is a paralysis of all extremities (quadriplegia) lasting at least three months. The diagnosis must be confirmed by a specialist physician, neurologist or traumatologist. **The right to benefit payment does not arise in cases of:** partial paralysis, transitory paralysis and paralysis caused by injury.	Report from a specialist physician – neurologist or traumatologist confirming this diagnosis. Date of claim's rise is the day, as of which the paralysis appeared (started).
100% SA + 20% bonus	**Blindness not related to injury (in both eyes)**	It is a complete and permanent loss of sight in both eyes caused by a disease that developed during the period of duration of this rider. **The right to benefit payment does not arise when:** the blindness was caused by injury.	Medical report from a specialist workplace describing the course of the disease of the eyes that caused permanent bilateral blindness. Day of claim's rise is the day, as of which the permanent blindness was determined by a specialist physician – ophthalmologist.
100% SA + 20% bonus	**Deafness not related to injury (hearing loss in both ears)**	It is a complete bilateral and permanent hearing loss that was caused by a disease that developed/started during the period of duration of this rider. The diagnosis must be confirmed by medical examination that includes audiometry and hearing threshold tests and a report from a specialist physician – an ENT specialist. **The right to benefit payment does not arise when**: the deafness was caused by injury.	Report from hospital, in the case of hospital stay in a specialist workplace (ENT) that has determined the diagnosis; report describing auxiliary investigations of the hearing apparatus (X-ray, CT, audiogram and other). Day of claim's rise is the day, as of which the permanent deafness has been determined by a specialist physician – an ENT specialist.
100% SA 20% bonus	**Malignant tumour**	It is a disease that manifests as the occurrence of malignant tumours with characteristic uncontrolled growth and spread of tumour cells and their penetration into healthy tissues. These diseases include leukemias, sarcomas, blastomas, malignant disorders of the lymphatic system (e.g. Hodgkin's disease), malignant disease of the bone marrow and some types of cancer. **The right to benefit payment does not arise when the diseases involved are:** a) tumour diseases in the presence of HIV infection; b) malignant skin melanomas with stage 1A depth (less than 1 mm, II or III without ulceration) according to the valid classification AJCC from 2002; c) uterine cervix dysplasia and carcinoma in stages CIN-1, CIN-2 and CIN-3; d) early stages of prostate cancer of TNM classification T1 including T1a as well as T1b or equivalent classification; e) all non-malignant (benign) tumours and polycythaemia vera; f) all pre-malignant stages, non-invasive tumour stages - the so-called carcinomas in situ and microinvasive findings; hyperkeratosis, squamous and basocellular forms of skin cancer.	Discharge report from hospital or a confirmed copy of a report by the specialist facility that has determined or confirmed the diagnosis of the malignant tumour, always stating the date on which the diagnosis was made; further photocopy of histological finding together with the number of the (diagnostic) preparation. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - oncologist or pathologist based on histological or other investigations that cannot be challenged and confirm the presence of progressive malignant disease.
100% SA + 20% bonus	**Non-malignant brain tumour**	These are non-malignant tumours of the brain, the meninges and medulla oblongata that pose danger to the life of the insured through compression of the surrounding tissue, and not as a result of their malignant nature. Such tumour must be confirmed through neurologist investigation and it must be recommended for neuro-surgical procedure by a neurologist. In cases where the tumour is evaluated as inoperable the neurologist examination must demonstrate permanent neurological consequences for the insured.	Comprehensive report from the specialist facility that has established or confirmed the diagnosis, always stating the date when the diagnosis was established, and including the results of investigations that demonstrate the severity of the non-malignant tumour (CT, MRI, X-ray and other investigations). Day of claim's rise is the day, as of which the diagnosis of a severe non-malignant tumour was established by a specialist physician – neurologist.

		The right to benefit payment does not arise in the following cases: simple cysts, granulomas, vascular malformations, haematomas, pituitary and spine tumours.	
100% SA + 20% bonus	**AIDS/HIV a) as a result of blood transfusion or b) as a profession-related (occupational) disease in health care workers**	Is an advanced AIDS disease or the demonstrated presence of infection with any HIV virus if the insured has been infected : a) through the transfusion of blood containing infected blood or blood products administered in an officially registered facility within the territory of the Czech Republic during the period of duration of the rider. Formation of antibodies corresponding to HIV infection must be demonstrated within 6 months of the administration of the transfusion; b) with an injection needle as a result of occupational injury. It is also necessary that the insured provide the results of a negative test for HIV antibodies that has been carried out immediately after the injury. Formation of antibodies corresponding to HIV infection must be demonstrated within 6 months of the injury. **Insurance coverage does not include:** persons with haemophilia.	For cases under a): a statement from an officially registered workplace in the Czech Republic that has administered the infected blood or blood derivative; further a positive result of investigation of antibodies against HIV within 6 months after the administration of the preparation. For cases under b) negative results of the test for HIV antibodies that was carried out within 7 days of the injury. Day of claim's rise is the day when the transfer of or infection with HIV occurred.
30% SA	**Primary muscular dystrophy– advanced stages**	A group of degenerative diseases of the muscles characterised by painful and weak (atrophic) muscles, as a result of damage sustained by the insured such that he or she is unable to perform at least three activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person. The rider only applies to cases caused by a new mutation. **The right to benefit payment does not arise in cases of:** insured with familial occurrence of these diseases.	Report from a specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - neurologist.
30% SA	**Coma, not related to injury**	This is a state of permanent deep unconsciousness of a patient who does not react to external stimuli and inner needs. The patient survives only as a result of the use of instruments supporting vital functions, such as controlled ventilation. Duration of the coma must be at least 96 hours. It is necessary to provide a neurologist report confirming the presence of residual neurologist finding. The coma must be documented by a report from the respective department of anaesthesiology and resuscitation. **The right to benefit payment does not arise in cases of:** coma caused by injury.	Report from a specialist physician - anaesthetist or neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the onset of the coma has been determined by the relevant specialist physician.
30% SA	**Paralysis of two extremities simultaneously, not related to injury**	It is a paralysis of at least two extremities (paraplegia, hemiplegia) lasting at least three months. **The right to benefit payment does not arise if:** the paralysis affects only one extremity (monoplegia), is only partial (paresis), is a transitory paralysis, or is related to injury.	Report from a specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the paralysis occurred.
30 % SA	**Amputation of upper and lower extremities, not related to injury**	It is an amputation of at least two extremities made necessary by a disease that developed during the period of duration of this raider, and is must concern the hands and/or feet at least in the wrist joint and/or in the ankle joint. The diagnosis must be confirmed by the attending physician. **The right to benefit payment does not arise if:** the amputation of upper and lower extremities is the necessary result of an injury.	Report from a specialist physician - surgeon providing a precise description of the causes, course and the level of amputation. Day of claim's rise is the day, as of which the amputation of the second extremity was carried out.
30% SA	**Juvenile idiopathic rheumatoid arthritis**	For the purposes of this rider, the stated diagnosis is to be understood as an autoimmune systemic disease affecting preferentially the small joints. The disease must be confirmed, without any doubt, by the relevant specialist physician. The diagnosis must be documented with a rheumatologist report and positive laboratory investigations, including positive values of inflammatory markers (CRP, erythrocyte sedimentation rate) and the levels of specific	Report from a specialist physician - rheumatologist with the results confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the specialist physician - rheumatologist.

		antibodies (i.e. RF - rheumatoid factor).	
30% SA	**Acute rheumatic fever**	Rheumatic fever in the sense of this rider is to be understood as an autoimmune reaction to the antibodies that are formed against the bacteria of beta-haemolytic streptococcus, with confirmed presence of complications mediated through cardiac damage (pericardium, epicardium, myocardium, endocardium including the valves), with the clinical symptoms of functionally severe cardiac failure assessed according to the NYHA classification to be class II–IV. The diagnosis must be documented by a medical report from a specialist workplace (internal medicine, cardiology, rheumatology) including echocardiography. Only acute cases are covered/indemnified. Not covered are states after a disease that has already taken place.	Report from specialist physician - rheumatologist, cardiologist, or internal medicine specialist with echocardiography findings confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% DA	**Systemic lupus erythematosus**	It is an autoimmune systemic disorder characterised by the development of autoantibodies against various organs of the patient.	Report from specialist physician - rheumatologist. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
30% SA	**Polyarteritis nodosa**	It is a systemic disease of the nature of vasculitis affecting multiple organs. It is necessary to document involvement of at least two of the following organ systems simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and specialist physician - rheumatologist based on biopsy investigation.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - rheumatologist.
30% SA	**Wegener's granulomatous vasculitis**	It is a systemic disease pf the nature of vasculitis affecting multiple organs simultaneously. It is necessary to document the involvement of at least two of the following organ systems simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist based on biopsy investigation.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by specialist physician - rheumatologist.
30% SA	**Kawasaki vasculitis**	It is a systemic disease in the form of vasculitis affecting multiple organs. It must be documented that at least two of the following organ systems are affected simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the specialist physician - rheumatologist.
30% SA	**Takayasu's vasculitis**	It is a systemic disease in the form of vasculitis affecting multiple organs. It must be documented that at least two of the following organ systems are affected simultaneously: kidneys, respiratory tract, heart, skin or locomotor apparatus. The diagnosis must be confirmed by biopsy and a specialist - rheumatologist.	Report from specialist physician - rheumatologist with the results of biopsy confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician - rheumatologist.
30% SA	**Encephalitis - Creutzfeldt-Jakob**	Creutzfeldt-Jakob disease is defined as a disease that causes permanent and irreversible damage to the brain tissue as a result of infection. It is always necessary to provide medical confirmation of the Creutzfeldt-Jakob disease. The diagnosis must be determined by a specialist physician from a neurology facility within the territory of the Czech Republic.	Report from a specialist physician - neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by a specialist physician - neurologist.
30% SA	**Tick-borne encephalitis**	This is an inflammation of the brain tissue caused by infection – through the virus of tick-borne encephalitis that results in a long-term damage characterised by the presence of neurological findings. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	Report from a specialist physician - infectologist or neurologist with laboratory results including the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30% SA	**Poliomyelitis (infantile cerebral palsy)**	It is an inflammation of the nervous tissue caused by the poliovirus. It must result in the development of a damage to the insured such that he or she is unable to perform at least three of common activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician

		the help of another person. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	
30% SA	**Encephalitis, other viral or bacterial**	It is an inflammation of the cerebral tissue caused by viral or bacterial infection that must result in a damage to the insured such that he or she is unable to perform at least three common activities of daily life, such as washing, getting dressed, independent ingestion of meals, using the bathroom, and taking medications, or he or she is permanently bed-ridden so he or she depends on the help of another person. The diagnosis must be determined by a specialist physician - infectologist or neurologist based on the results of laboratory investigations including the results of lumbar puncture.	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician.
30% SA	**Meningitis caused by viruses, bacteria**	It is an inflammation of the membranes covering the brain and of the brain caused by viral or bacterial infection. The diagnosis must be documented by a report from the relevant infectologist or neurologist and supported by positive findings of the results of investigation of the cerebrospinal fluid (obtained by lumbar puncture) and other findings needed to confirm this disease with necessary laboratory results and tests including serology.	Report from specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician.
30% SA	**Meningoencephalitis caused by viruses or bacteria**	It is an inflammation of the membranes covering the brain and the brain caused by viral or bacterial infection. The diagnosis must be documented by a report from the relevant infectologist or neurologist and be supported by positive findings of the results of investigation of the cerebrospinal fluid (obtained by lumbar puncture) and other findings needed to confirm this disease with necessary laboratory results and tests including serology.	Report from a specialist physician - infectologist or neurologist with laboratory results that include the results of lumbar puncture confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% SA	**Leptospirosis**	This diagnosis must be documented with the presence of acute complaints, corresponding clinical findings and correlated laboratory tests (especially serological, namely specific IgM antibodies). The diagnosis must be confirmed by a report from a specialist physician – hepatologist or infectologist.	Report from a specialist physician - hepatologist or infectologist with the results of laboratory tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% SA	**Fulminant hepatitis**	It is a massive necrosis of the liver tissue occurring in the course of acute viral hepatitis that results in the development of liver failure characterised by the presence of jaundice, rapid reduction of the size of the liver, rapid deterioration of liver function tests, and the development of hepatic encephalopathy within 1 months of the onset of complaints. The diagnosis must be confirmed by a report from a specialist physician - hepatologist or infectologist.	Report from a specialist physician - hepatologist or infectologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% SA	**Hepatitis C caused by hepatitis C virus**	This diagnosis must be documented by laboratory tests (serology) that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of an ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist. **The right to benefit payment does not arise if**: the cases are caused by alcohol or other addictive substance abuse.	Report from specialist physician - hepatologist or infectologist with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% SA	**Hepatitis D caused by hepatitis D virus**	This diagnosis must be documented by laboratory (serology) tests that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist.	Report from specialist physician - hepatologist or infectologist with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30% SA	**Hepatitis E caused by**	This diagnosis must be documented by laboratory	Report from specialist physician - hepatologist or infectologist

	hepatitis E virus	(serology) tests that, together with the complaints, clinical findings and other laboratory tests (including liver function tests), make it possible for an infectologist to clearly confirm the stated diagnosis of ongoing disease. The diagnosis must be supported by the report of relevant specialist physician - hepatologist or infectologist.	with the results of serology tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis has been determined by the relevant specialist physician.
30% SA	**Lyme disease (Lyme borreliosis)**	Lyme borreliosis in the sense of this rider is to be understood as the determination of diagnosis of the disease in stage II and III of by laboratory testing, and must be confirmed by the relevant specialist workplace – neurology or infectious diseases department. It must be documented by the presence of clinical symptoms, serology investigation of blood, and possibly also, according to the location of the damage, by the investigation of the cerebrospinal fluid or the fluid obtained by puncture from a joint. The diagnosis must be documented by a medical report from a specialised workplace.	Report from specialist physician - infectologist or neurologist confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.
30% SA	**Diabetes mellitus, type I, with intensified insulin regimen (insulin-dependent)**	For the purposes of this rider, diabetes mellitus is defined as a chronic disease (acquired during the course of life of the insured) as a result of which the condition of chronic hyperglycaemia develops. This diagnosis must be documented with a medical report confirming the diagnosis of type I diabetes mellitus that requires, because of its seriousness, treatment with regular applications of insulin injections, and it is required that such treatment last for at least 2 years.	Report from a specialist physician - paediatrician or diabetologist that confirms this diagnosis. Day of claim's rise is the day, on which the insured has been treated with insulin for 2 years.
30% SA	**Coeliac disease**	It is an autoimmune disorder where the primarily affected organ is the small intestine, and the insured must permanently observe gluten-free diet. The diagnosis including the statement of the histological findings from a biopsy from the involved organ and the necessity to observe the dietary regiment must be confirmed by objective findings made by a specialised paediatric or gastroenterology workplace.	Report from a specialist physician - paediatrician or gastroenterologist confirming this diagnosis including the results of laboratory investigations and biopsy. Date of claim's rise is the day, as of which the diagnosis was determined by the specialist physician.
30% SA	**Acute subglottic laryngitis (ASL) or acute epiglottitis**	An acute laryngitis for the purposes of this rider is defined as exclusively serious forms that require admission to hospital and urgent invasive intervention, such as intubation, coniotomy, coniopuncture or tracheostomy.	The diagnosis must be confirmed by a report on hospital stay. Date of claim's rise is the day, as of which the diagnosis was determined by the specialist physician.
30% SA	**Peritonsillar abscess**	It is a complication of tonsillitis of the palatine tonsils. The diagnosis must be confirmed by a report on the performance of the corresponding treatment procedure by a specialist - otorhinolaryngologist.	The diagnosis must be confirmed by a report from a specialist physician. Date of claim's rise is the day, as of which the diagnosis was determined by the specialist physician - otorhinolaryngologist.
30% SA	**Tetanus**	It is an infectious disease caused by the bacterium Clostridium tetani. It must be a more severe form of the disease that necessitates admission to hospital. The diagnosis must be documented with the demonstration of the presence of the bacterium Clostridium tetani.	Report from a specialist physician - infectologist confirming this diagnosis. Day of claim's rise is the day, as of which this diagnosis has been determined by the relevant specialist physician - infectologist.
30% SA	**Intestinal obstruction treated surgically**	For the purposes of this rider, the cases must be cases of the so-called ileus state. It is defined as an acute abdomen characterised as disturbed intestinal passage and distension of the intestinal loops above the affected segment. Unless the cause is removed the affected person experiences a threat to his or her live.	The diagnosis must be confirmed by a report on hospital stay and surgery. Day of claim's rise is the day, on which the surgery for ileus was carried out.
10% SA	**Carcinoma in situ**	Is a pre-invasive tumour, i.e. a tumour that has not yet developed into the picture of a malignant tumour. The diagnosis must be determined with histology. There is no stromal invasion. It must be clear from the documentation that the tumour has been assigned the histopathology numeric code MN 8000-9999/2. The key for the differentiation of carcinoma in situ is the number after the forward slash /2/.	Report by specialist physician oncologist, gynaecologist, gastroenterologist, urologist or other specialist physician together with the results of histological tests confirming this diagnosis. Day of claim's rise is the day, as of which the described diagnosis was determined by the relevant specialist physician.

Special insurance conditions for insurance of the type
ACCIDENTAL DISABILITY RIDER 0026

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the rider for case of accident and consequences 0026 (here in after only "SPC 0026") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC 0026 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC 0026.
3. This rider may be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. Insurance of the following insured events is arranged within this rider:

a) **Accident of the insured person if it is mentioned in Table 1 of the Supplement to these SPC 0026;**

b) **Accident if it leaves permanent consequences mentioned in Table 3 of the Supplement to these SPC 0026 and these permanent consequences are diagnosed at the insured person by the relevant doctor within 3 years since the accident.** Permanent consequences of an accident mean physical or functional bodily injury that is declared as permanent condition by the relevant doctor after termination of the treatment,

c) **Hospitalisation of the insured person due to an accident.**

2. Hospitalisation of the insured person due to an accident represents an insured event only if hospital treatment of the insured person lasts at least 11 calendar days following one after another and at the same time if the insured person is treated in a hospital that works under permanent professional medical management, disposes of sufficient diagnostic and therapeutic possibilities, works according to generally acknowledged methods of medical science, keeps records about health status and course of treatment and its operation is in compliance with relevant valid legal regulations.
3. In case of an insured event according to paragraph 1 letter a) of this Article the insurance company will pay the benefit to the beneficiary in the amount mentioned in Table 1 of the Supplement to these SPC 0026 for the given injury. In case of an insured event according to paragraph 1 letter b) of this Article, the insurance company will pay the benefit to the beneficiary in the amount mentioned in Table 3 of the Supplement to these SPC for the given permanent consequences of the accident.
4. If more injuries mentioned in Table 1 of the Supplement to these SPC 0026 occur within a single accident or if the injuries cause more permanent consequences mentioned in Table 3 of the Supplement to these SPC 0026, benefit payment for the injuries and/or permanent consequences of the accident is limited by the amount of 100 000 CZK per accident. In case of a partial loss of an organ or its function, the level of benefit payment will be derived from the benefit specified for its complete loss.
5. In case of an insured event according to paragraph 1 letter c) of this Article, the insurance company will pay the benefit to the insured person for each day of hospitalisation on the level of the daily allowance arranged in Table 2 of the Supplement to these SPC 0026 and this starting by the day of the insured person's admission to hospitalisation and terminating by the day when hospitalisation is finished or by the date of the rider's lapse according to the situation, which of these facts occurs earlier, however, 365 days within one insured event at the most. The first and the last day of hospitalisation are jointly considered as one day. Claim to payment of daily allowance does not arise for days when the insured person did not stay in the hospital at all.
6. In case of an insured event according to paragraph 1 letter c) of this Article, the insurance company will provide the benefit to the insured person as a single payment after termination of hospitalisation but always only after the insured person has proven his/her claim to benefit payment to it (he/she will submit a confirmation from the doctor and the properly completed Claim notification form).
7. **An insured event is reported to the seat of the insurance company without an unnecessary delay, and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is neither able to notify the insurance company of the insured event himself/herself due to the severity his/her health status nor to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event. **An insured event according to paragraph 1 letter c) of this Article is reported latest within 15 calendar days after termination of hospitalisation. The insurance company is entitled to adequately decrease benefit payment, and this by up to 50 %, in case of late notification of the insured event.**
8. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in which amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of the current premium is determined by the tariff fixed amount for the entire duration of the scheme (regardless of the age of the insured, the insured period or any other value).

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to indemnification arise if the period of 1 year from insurance event pursuant to Art. 2 paragraph. 1 point. a) will further injury of the same type.**
2. **The right to benefit payment does not arise if the permanent consequences of accident occurred in direct or indirect connection with:**

a) Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;

b) Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;

c) Mental disorder of the insured person;

d) Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;

e) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;

f) Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

g) Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;

h) Professional operation of a sport by the insured person;

i) Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;

j) Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;

k) Worsening of the insured person's disease, which occurred due to the accident of the insured person;

l) Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

m) Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
2. If a period is set for a certain act in these SPC 0026 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
3. **The insurance company has the right to perform an adequate change in these SPC 0026 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC 0026 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company. The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC 0026 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC 0026 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC 0026 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Daily allowance
Amount agreed in the insurance contract that is paid per day of the insured event's duration;

Hospitalisation
Provision of hospital in patient care to the insured person due to an accident of the insured person that is necessary from medical point of view; it is considered as necessary from medical point of view if the insured person's treatment must be performed in a hospital as in patient care due to the severity of the disease or due to the character of treatment;

Gross income
Amount corresponding to the gross salary (if it is an employee) and/or income from business activity or from another independent gainful activity after deduction of expenditures according to the tax return for the past taxation period (if it is not an employee).

Firm fixation
Plaster cast, rigid orthesis, aluminium fixator, plastic fixation, Desaults bandage; the use of zinc-glue, starch fibre bandage, bandage, roller bandage or taping is not considered as firm fixation;

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF ACCIDENTAL DISABILITY RIDER 0026	
Table 1: Compensation for injuries without permanent damage	
001 Post-traumatic subdural hematoma of the brain	10 000 CZK
002 Post-traumatic pneumothorax	10 000 CZK
003 Torn ligaments of the shoulder and knee requiring operative solutions	10 000 CZK
004 Posttraumatic complete rupture of the Achilles tendon	5000 CZK
005 Skin burns II. b) or III. degree exceeding 9% of the body surface (not caused by sunlight)	5000 CZK
006 Fracture or multiple fractures of bones or skull bones treated operatively (bloody reposition)	10 000 CZK
007 Spine fracture treated operatively	10 000 CZK
008 Fracture or multiple fractures of bone(s) of the upper limb treated operatively (bloody reposition)	10 000 CZK
009 Fracture or multiple fractures of bone(s) of the lower extremity treated operatively (bloody reposition)	10 000 CZK
010 Fracture or multiple fractures of pelvic bone(s) treated operatively (bloody reposition)	10 000 CZK
011 Fracture or multiple fractures (treated conservatively):	
a) bone(s) of the upper limbs, with the exception of the metacarpal bones and phalanges	5000 CZK
b) bone(s) of the lower extremity, with the exception of the phalanges	5000 CZK
c) pelvic bone	5000 CZK
d) collarbone	5000 CZK
e) ribs	5000 CZK
f) vertebrae	5000 CZK
g) skull bone(s)	5000 CZK
h) metacarpal bone(s) and phalanges of hand	2000 CZK
i) articles toes	2000 CZK
Table 2: Daily dose in case of hospitalization	
012 Daily dose in case of hospitalization due to accident	100 CZK/day
Table 3: Compensation for permanent disability	
013 nose loss solved by plastic surgery	2500 CZK
014 Total loss of the pinna solved facelift	2500 CZK
015 Total loss of a permanent tooth (including to the canine)	1000 CZK
016 Post-traumatic epilepsy Jackson's type	12 500 CZK
017 Loss of finger, at least two complete articles	12 500 CZK
018 The loss of one entire phalanx of hand	12 500 CZK
019 The loss of two whole articles of thumb	20 000 CZK
020 Loss of all toes incl. inches, and all their articles	15 000 CZK
021 The loss of two entire toe articles	12 500 CZK
022 Total loss of hearing of one ear while keeping the ear to the other ear	6 250 CZK
023 Condition after tracheotomy with a permanently cannulated	12 500 CZK
024 Traumatic injury, which resulted in the granting of partial disability	12 500 CZK
025 Cerebral fistula after injury scum of the skull (likvororea)	12 500 CZK
026 Complete defect in the cranial vault in the range of over 10 cm^2	12 500 CZK
027 Loss of the lens in one eye (including accommodation disturbances)	6250 CZK
028 Loss of lenses in both eyes (including accommodation disorders)	12 500 CZK

Special insurance conditions for insurance of the type
DAILY ALLOWANCE RIDER OF ACCIDENT TREATMENT WITH PROGRESSION CDL1
DAILY ALLOWANCE RIDER OF CHILD'S ACCIDENT TREATMENT WITH PROGRESSION CDL2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the Daily allowance rider of accident treatment with progression CDL1 and Daily allowance rider of child's accident treatment with progression CDL2 (hereinafter only "SPC CDL1 and CDL2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CDL1 and CDL2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CDL1 and CDL2.
3. These riders can be arranged only as additional insurance to the main life insurance (hereinafter only the „Main coverage").
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event within these riders is an injury or bodily harm of the insured person as a result of an accident (hereinafter only the "Injury") specified in the relevant part of Chart 1 of the Supplement to these SPC CDL1 and CDL2 (hereinafter only "Chart 1"). Injuries, at which it is mentioned in Chart 1 that no benefit is paid for them, do not represent an insured event.**
2. **Also an injury not mentioned in Chart 1, which is the closest to an injury specified in Chart 1 by its nature and severity on the basis of a judgement made by the insurer and his contract doctor that is an insured event according to the previous paragraph (hereinafter only the "Assimilation"), represents an insured event whereas an assimilated injury is further regarded as the injury, to which it was assimilated.**
3. In case of an insured event the insurance company will pay the benefit to the insured person determined as product of the arranged daily allowance and the number of days of standardised period of the injury's treatment according to Chart 1, further multiplied by the progression coefficient according to the below-mentioned chart.

Standardised period of the injury's treatment	Progression coefficient
to 89 days	1
90 – 169 days	2
170 – 365 days	3

4. If the real period of the injury's treatment under medical supervision exceeds the standardised period of treatment due to the reason that some of the complications mentioned in Chart 2 of the Supplement to these SPC CDL1 and CDL2 (hereinafter only „Chart 2") occurs during the treatment, the insurance company will pay additional benefit for case of complication determined as product of the arranged daily allowance and the difference in the number of days of real period of treatment for the period of the rider's duration, however, 365 days at the most, and the number of days of standardised period of the given injury's treatment; the highest value of this difference for individual complications is mentioned in Chart 2. The progression coefficient is not applied at the benefit for case of complications.
5. **The insurance company will pay additional benefit for hospitalisation if treatment of the injury requires hospitalisation of the insured person within 24 hours from the moment of the accident that is longer than 24 hours following one after another; the level of benefit for hospitalisation will be determined as product of the arranged daily allowance and the number of days of hospitalisation for the period of the rider's CDL1 duration at the rider CDL1 and as product of half of the arranged daily allowance and the number of days of hospitalisation for the period of the rider's CDL2 duration at the rider CDL2.**
6. **If several injuries were caused to the insured person by a single accident at the same time (hereinafter only the „Concurrence"), the claim to benefit payment arises only for one injury with the longest standardised period of treatment; determined as product of the longest standardised period of treatment, daily allowance and progression coefficient in compliance with paragraph 3. of this Article. The level of benefit for case of a complication in case of concurrence is equal to the product of the arranged daily allowance and the difference in the number of days of the real period of treatment for the period of the rider's duration, however, at the most up to the limit according to the given complication mentioned in Chart 2 of the Supplement and the number of days of standardised period of the injury's treatment with the longest standardised period of treatment. The highest value of this difference for individual complications is mentioned in Chart 2 of the Supplement. The progression coefficient is not applied at benefit payment for case of a complication.**
7. The insurance company will pay the benefit in a single payment after the insured person has proven his/her claim to the benefit (he/she will submit a properly completed Claim notification form confirmed by the doctor including the medical report).
8. **An insured event is reported to the seat of the insurance company without an unnecessary delay and this on the prescribed "Claim notification form" of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is neither able to notify the insurance company of the insured event nor able to ask for benefit payment himself/herself due to the severity of his/her health status, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of the bank account arranged in the insurance contract for these purposes unless set otherwise by the insured person within investigation of the insured event.
9. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the arranged daily allowance for this rider and the premium rate set in the tariff of charges.

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in case when the treatment in question is a necessary treatment of extremity joint luxation that has been treated in other ways than reduction (correction) carried out by a physician.**
2. **The right to benefit payment does not arise if the injury of the insured person occurred in direct or indirect connection with :**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Mental disorder of the insured person;**
   d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;**
   e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   f) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared,**

kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

g) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**

h) **Professional operation of a sport by the insured person;**

i) **Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;**

j) **Disease or accidents that occurred before the insurance start with exception of cases when a health status questionnaire was completed at conclusion of the insurance contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of existence of the mentioned disease;**

k) **Accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**

l) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**

m) **Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 meters and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**

n) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

3. **The right to benefit payment for hospitalisation does not arise if:**

a) **It is about a curative stay of the insured person in sanatoriums, health spas, rehabilitation centres or rehabilitation departments of health care centres; this is not valid in case when the stay there represents a necessary part of the treatment of the insured person's accident from medical point of view and the insurance company expressed its prior written approval with this stay;**

b) **It is about a curative stay of the insured person in treatment centres of alcoholism, drug and gaming addictions;**

c) **It is about hospitalisation of the insured person in nursing homes for long-term care, in medical institutions for treatment of tuberculosis and respiratory diseases and in other professional health care institutions, special children's health care facilities, at the insured person's stay in institutes of social care and at army medical facilities;**

d) **It is about hospitalisation of the insured person that is connected only with the need of nursing and day care no matter whether it is about partial hospitalisation with day or night treatment.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the day of the main coverage anniversary.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in himself/herself or through a legitimate representative truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company), and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The maximum level of daily allowance, which can be arranged, is limited by the amount of gross annual income of the insured person (CDL1) or of the legitimate representative of the insured child (CDL2) as of the day of the rider's arrangement according to the below-mentioned chart. The maximum level of daily allowance is judged in the sum of all daily allowance policies or the necessary period of the accident's treatment, which the insured person has arranged at the insurer. The insurance company has the right to verify the insured person's income at an insured event. The income is proven by a confirmation from the payer of salary about the insured person's income as an employee for the period of 3 calendar months following one after another antecedent to the day of the rider's start and if the insured person is not an employee, the income is proven by a certified copy of the tax return for the last taxation period antecedent to the day of the rider's start.**

Maximum daily allowance in relation to income of the insured person or of the legitimate representative					
Gross annual income	Maximum daily allowance		Gross annual income	Maximum daily allowance	
	CDL1	CDL2		CDL1	CDL2
0 - 359 999 CZK	500 CZK	500 CZK	744 000 - 803 999 CZK	1 300 CZK	800 CZK
360 000 - 419 999 CZK	600 CZK	600 CZK	804 000 - 875 999 CZK	1 400 CZK	800 CZK
420 000 - 467 999 CZK	700 CZK	700 CZK	876 000 - 947 999 CZK	1 500 CZK	800 CZK
468 000 - 527 999 CZK	800 CZK	800 CZK	948 000 - 1 007 999 CZK	1 600 CZK	800 CZK
528 000 - 575 999 CZK	900 CZK	800 CZK	1 008 000 - 1 067 999 CZK	1 700 CZK	800 CZK
576 000 - 635 999 CZK	1 000 CZK	800 CZK	1 068 000 - 1 139 999 CZK	1 800 CZK	800 CZK
636 000 - 695 999 CZK	1 100 CZK	800 CZK	1 140 000 - 1 211 999 CZK	1 900 CZK	800 CZK
696 000 - 743 999 CZK	1 200 CZK	800 CZK	1 212 000 CZK and more	2 000 CZK	800 CZK

3. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on about change in other data or circumstances that have an influence on the insurance risk, benefit payment or existence of insurance interest (e.g. change in working, business, sports or other interest activity, change in health condition, decision concerning disability and disability pension, acknowledgement of old age pension and the like).**
4. **The insurance company has to right to adequately decrease benefit payment in cases when the policyholder or the insured person did not report change of profession or of registered sports activity to it, which would mean inclusion of the insured person into a higher risk group.**
5. If a period is set for a certain act in these SPC CDL1 and CDL2 and/or in relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest

following working day. The insurance company reserves the right to adequately prolong the arranged periods in case that there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.

6. **The insurance company has the right to perform an adequate change in these SPC CDL1 and CDL2 and/or tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CDL1 and CDL2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective date of such a change must be set in such a way that there is a period of at least 45 calendar days between delivery of the new wording of SPC CDL1 and CDL2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC **CDL1 and CDL2** and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CDL1 and CDL2 and/or in the tariff of charges in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

All terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Daily allowance

Amount agreed in the insurance contract that is paid per day of the insured event's duration;

Hospitalisation

Provision of hospital in patient care to the insured person due to an accident of the insured person that is necessary from medical point of view; it is considered as necessary from medical point of view if the insured person's treatment must be performed in a hospital as in patient care due to the severity of the disease or due to the character of treatment;

Gross income

Amount corresponding to the gross salary (if it is an employee) and/or income from business activity or from another independent gainful activity after deduction of expenditures according to the tax return for the past taxation period (if it is not an employee).

Firm fixation

Plaster cast, rigid orthesis, aluminium fixator, plastic fixation, Desaults bandage; the use of zinc-glue, starch fibre bandage, bandage, roller bandage or taping is not considered as firm fixation;

Professional operation of sport

Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident

Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Open fracture

A fracture that results from a primary injury that is caused through an injury mechanism and not by a surgical procedure.

Special insurance conditions for insurance of the type
RIDER FOR MINOR INJURY COMPENSATION CDU1
RIDER FOR CHILD´S MINOR INJURY COMPENSATION CDU2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of the Rider of minor injury compensation CDU1 and Rider of child's minor injury compensation CDU2 (hereinafter only "SPC CDU1 and CDU2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CDU1 and CDU2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CDU1 and CDU2.
3. These riders can be arranged only as additional insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to these riders.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. An insured event within the rider CDU1 is an injury of the insured person caused by an accident specified in Chart 1 of the Supplement to these SPC CDU1 and CDU2, an insured event within the rider CDU2 is an injury of the insured person caused by an accident specified in Chart 2 of the Supplement to these SPC CDU1 and CDU2.
2. In case of an insured event the insurance company will pay a single benefit corresponding to the sum assured mentioned for the given injury and the arranged multiple of the sum assured in the relevant chart of the Supplement to these SPC CDU1 and CDU2.
3. **If a single accident caused several injuries to the insured person at the same time, the insurance company will pay the benefit only for the injury with the highest sum assured**.
4. **An insured event is reported to the seat of the insurance company without an unnecessary delay since the accident and this on the prescribed "Claim notification form" of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event.
5. The insurance company will pay the benefit after the claim to benefit payment has been proven to it (by submission of a confirmation from the doctor and a properly completed Claim notification form).
6. **The riders do not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to a multiple of the arranged sum assured and the premium rate set in the tariff of charges.

Article 4 - What period do I arrange the rider for?

1. The riders are arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in case of contusions or sprains if such treatment does not involve surgical, orthopaedic or traumatology examination and in cases of contusion, the condition of the presence of oedema, haematoma or effusion in the subcutaneous tissue is not met at the same time.**
2. **The right to benefit payment does not arise in case of contusions or sprains caused by accident if this accident occurred earlier than one year after the previous accident that also resulted in contusion or sprain, which was an insured event.**
3. **The right to benefit payment does not arise if the injury occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Mental disorder of the insured person;**
   d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which effects the whole body of the insured person unless the accident was their exclusive cause;**
   e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   f) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   g) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**
   h) **Professional operation of a sport by the insured person;**
   i) **Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;**
   j) **Disease or accidents that occurred before the insurance start with exception of cases when a health status questionnaire was completed at conclusion of the insurance contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of existence of the mentioned disease;**
   k) **Accident of the insured person that occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**
   l) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**
   m) **Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 meters and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**
   n) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract

additionally) and this as of the day of the main coverage anniversary.

4. **The rider CDU1 also lapses by the day of extinction of the rider CDL1 of the same insured person and the rider CDU2 lapses by the day of extinction of the rider CDL2 of the same insured person.**
5. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do these rider concern?

1. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on about change in other data or circumstances that have an influence on the insurance risk, benefit payment or existence of insurance interest (e.g. change in working, business, sports or other interest activity, change in health condition, decision concerning disability and disability pension, acknowledgement of old age pension and the like).**
2. **The insurance company has the right to adequately decrease benefit payment in cases when the policyholder or the insured person did not report change of profession or of registered sports activity to it, which would mean inclusion of the insured person into a higher risk group.**
3. If a period is set for a certain act in these SPC CDU1 and CDU2 and/or in relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods in case that there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CDU1 and CDU 2 and/or tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CDU1 and CDU2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective date of such a change must be set in such a way that there is a period of at least 45 calendar days between delivery of the new wording of SPC CDU1 and CDU2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC **CDU1 and CDU2** and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CDU1 and CDU2 and/or in the tariff of charges in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

1. These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Firm fixation
Firm fixation is defined as the use of plaster cast, rigid orthesis, aluminium fixator, plastic fixation, Desaults bandage. The use of zinc-glue, starch fibre bandage, bandage, roller bandage, or taping is not considered as firm fixation.

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER AT HOSPITAL STAY DUE TO ACCIDENT OR DISEASE CHO1
RIDER AT HOSPITAL STAY DUE TO ACCIDENT OR DISEASE CHO4
RIDER AT A CHILD´S HOSPITAL STAY DUE TO ACCIDENT OR DISEASE CHO2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of rider at hospital stay due to accident or disease CHO1 and of rider at hospital stay due to accident or disease CHO4 (adult rider) and rider at a child's hospital stay due to accident or disease CHO2 (child rider) (hereinafter only „SPC CHO1/CHO4 and CHO2") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CHO1/CHO4 and CHO2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CHO1/CHO4 and CHO2.
3. These riders can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage"). **Daily allowance rider at hospital stay CHO1 and daily allowance rider at hospital stay CHO4 cannot be arranged concurrently.** Unless explicitly mentioned otherwise further in these SPC CHO1/CHO4 and CHO2, any of the riders SPC CHO1, CHO4 and CHO2 specified above is understood by the term rider (in singular).
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event within this rider is hospitalisation of the insured person as a result of an accident or disease.**
2. Hospitalisation of the insured person represents an insured event only if lasts at least 24 hours and at the same time if the insured person is treated in a hospital, which works under a permanent professional medical management, disposes of sufficient diagnostic and therapeutic possibilities, works according to generally acknowledged methods of medical science, keeps records about health status and course of treatment and its operation is in compliance with relevant valid legal regulations.
   Hospitalisation of the insured person, which occurred before expiry of the waiting period of 3 months from the rider's start due to a disease (or delivery), does not represent an insured event. This waiting period is prolonged to 8 months in case of hospitalisation in connection with teeth treatment, preparation of dentures and jaw orthopaedics and jaw surgery performance and further on in case of hospitalisation in connection with pregnancy or delivery.
3. In case of an insured event the insurance company will pay the benefit to the insured person for each day of hospitalisation in the amount of the arranged daily allowance and this starting by the day of acceptance of the insured person for hospitalisation and ending by the day when hospitalisation is terminated or by the date of the rider's extinction according to the situation, which of these facts occurs earlier, however, 52 weeks at the most. The first and last days of hospitalisation are jointly considered as one day.
   Claim to payment of daily allowance in case of hospitalisation does not arise for days when the insured person did not stay at the hospital at all.
4. The insurance company will pay the benefit to the insured person after termination of hospitalisation as a single payment but always only after the insured person has proven his/her claim to benefit payment to it (he/she submits confirmation from the doctor and properly completed Claim notification form).
5. **An insured event is reported to the seat of the insurance company without an unnecessary delay, however, latest within 15 calendar days after termination of hospitalisation and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal. **In case of belated claim notification, the insurance company is entitled to adequately decrease benefit payment and this by up to 50 %.** If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status in case of the daily allowance rider at hospital stay CHO1 or CHO4 and he/she is not even able to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event. In case of the daily allowance rider at a child's hospital stay CHO2, the insured event is reported by the insured person or by his/her legal representative.
6. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium for case at hospital stay as a result of an accident or disease CHO1 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges for the topical age of the insured person. Specific level of regular premium for the first insurance year of this rider, for which it is arranged at the time of increasing premium rate (so-called natural premium), is mentioned in the insurance contract for the first insurance year of the rider (or in the proposal for change in the insurance contract) and specific level of regular premium for each other insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written announcement to the policyholder latest 8 weeks before anniversary of the main coverage.
3. The amount of regular premium for case of hospital stay as a result of an accident or disease CHO4 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges for the entire insurance period in dependence on the age of the insured person as of the rider's start.
4. The amount of regular premium for case of hospital stay as a result of an accident or disease CHO2 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges.

Table of natural rates CHO1						
Age	15-39	40-44	45-49	50-54	55-59	60-65
Rate (in CZK)	**19**	**22**	**25**	**30**	**35**	**40**

Article 4 - What period do I arrange the rider for?

1. The riders are arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise in case of daily allowance rider at a child's hospital stay CHO2 if the hospitalisation occurred in direct or indirect connection with congenital disorders and/or accidents arisen as their result.**
2. **The right to benefit payment does not arise if the hospitalisation occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Mental disorder of the insured person;**
   d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**

e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**

f) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**

g) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**

h) **Professional operation of a sport by the insured person;**

i) **Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them** (this exception is valid only for daily allowance rider at hospital stay CHO1 and CHO4);

j) **Disease or accidents that occurred before the insurance start with exception of cases when a health care questionnaire was completed at the conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the existence of the mentioned disease;**

k) **Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**

l) **Worsening of the insured person's disease, which occurred due to the accident of the insured person;**

m) **Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**

n) **Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Exclusions mentioned in this paragraph under letters d), f), i) – l) are valid only in case that it is about hospitalisation due to the accident.

3. **In addition, the right to benefit payment does not arise if:**

a) **Hospitalisation of the insured person – a woman, occurs due to artificial interruption of her pregnancy because of a different than health indication;**

b) **It is about a curative stay of the insured person in sanatoriums, health spas, rehabilitation centres or rehabilitation departments of health care centres; this is not valid in case when the stay there represents a necessary part of the treatment of the insured person's accident from medical point of view and the insurance company expressed its prior written approval with this stay;**

c) **It is about a curative stay of the insured person in treatment centres of alcoholism, drug or gaming addictions;**

d) **It is about hospitalisation of the insured person in nursing homes for long-term care, in medical institutions for treatment of tuberculosis and respiratory diseases and in other professional health care institutions, special children's health care facilities, at the insured person's stay in institutes of social care and at army medical facilities**;

e) **It is about hospitalisation of the insured person that is connected only with the need of nursing and day care no matter whether it is about partial hospitalisation with day or night treatment**.

4. **Infertility is neither considered as a disease nor as an accident that means claim to benefit payment does not arise at hospitalisation due to this reason** (physiological delivery is also not considered as a disease, nevertheless, hospitalisation in connection with delivery is an insured event according to these SPC CHO1/CHO4 and CHO2).

5. **If a hospitalisation occurs due to a disease within the period of 3 months from the day when the arranged daily allowance to this rider was increased on the basis of the policyholder's request, the insurance company will decrease benefit payment to the lowest daily allowance valid for the last 3 months before the day of the rise of this insured event; if the insured event is hospitalisation in connection with teeth treatment, preparation of dentures and jaw orthopaedics and jaw surgery performance or in connection with a pregnancy or delivery, the period mentioned in the previous sentence is prolonged to 8 months.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do these rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged (in case of daily allowance rider of a child's hospital stay CHO2 himself/herself or through a legal representative) to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it. **Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.**
2. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
3. If a period is set for a certain act in these SPC CHO1/CHO4 and CHO2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
4. **The insurance company has the right to perform an adequate change in these SPC CHO1/CHO4 and CHO2 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CHO1/CHO4 and CHO2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days

between delivery of the new wording of SPC CHO1/CHO4 and CHO2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CHO1/CHO4 and CHO2 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CHO1/CHO4 and CHO2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

1. These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims, does not arise to the insurance company;

Daily allowance
Amount agreed in the insurance contract that is paid per day of the insured event's duration;

Hospitalisation
Provision of hospital in patient care to the insured person due to a disease or an accident of the insured person or in connection with delivery that is necessary from medical point of view and if it is hospitalisation due to a disease, which started on the territory of the Czech Republic during the period of the rider's duration at the same time; it is considered as necessary from medical point of view if the insured person's treatment must be performed in a hospital as in patient care due to the severity of the disease or due to the character of treatment;

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on the periods among the dates of the main coverage anniversaries following one after another;

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University;

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company;

Accident
Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type
RIDER AT HOSPITAL STAY DUE TO ACCIDENT CHU1
RIDER AT HOSPITAL STAY DUE TO ACCIDENT CHU4
RIDER AT A CHILD´S HOSPITAL STAY DUE TO ACCIDENT CHUF

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions of rider at hospital stay due to accident CHU1 and of rider at hospital stay due to accident CHU4 (adult rider) and child rider for case of hospitalisation due to an accident CHUF (child rider) (hereinafter only „SPC CHU1/CHU4 and CHUF“) create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only “GTC”).
2. Provisions of these SPC CHU1/CHU4 and CHUF are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CHU1/CHU4 and CHUF.
3. These riders can be arranged only as complementary insurance to the main life insurance (hereinafter only the “Main coverage”). **Rider at hospital stay due to accident CHU1 and rider at hospital stay due to accident CHU4 cannot be arranged concurrently.** Unless explicitly mentioned otherwise further in these SPC CHU1/CHU4 and CHUF, any of the riders SPC CHU1, CHU4 and CHUF specified above is understood by the term rider (in singular).
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event within this rider is hospitalisation of the insured person.**
2. Hospitalisation of the insured person represents an insured event only if lasts at least 24 hours and at the same time if the insured person is treated in a hospital, which works under a permanent professional medical management, disposes of sufficient diagnostic and therapeutic possibilities, works according to generally acknowledged methods of medical science, keeps records about health status and course of treatment and its operation is in compliance with relevant valid legal regulations.
   Hospitalisation of the insured person, which occurred before expiry of the waiting period of 3 months from the rider’s start due to a disease (or delivery), does not represent an insured event. This waiting period is prolonged to 8 months in case of hospitalisation in connection with teeth treatment, preparation of dentures and jaw orthopaedics and jaw surgery performance and further on in case of hospitalisation in connection with pregnancy or delivery.
3. In case of an insured event the insurance company will pay the benefit to the insured person for each day of hospitalisation in the amount of the arranged daily allowance and this starting by the day of acceptance of the insured person for hospitalisation and ending by the day when hospitalisation is terminated or by the date of the rider’s extinction according to the situation, which of these facts occurs earlier, however, 52 weeks at the most. The first and last days of hospitalisation are jointly considered as one day.
   Claim to payment of daily allowance in case of hospitalisation does not arise for days when the insured person did not stay at the hospital at all.
4. The insurance company will pay the benefit to the insured person after termination of hospitalisation as a single payment but always only after the insured person has proven his/her claim to benefit payment to it (he/she submits confirmation from the doctor and properly completed Claim notification form).
5. **An insured event is reported to the seat of the insurance company without an unnecessary delay, however, latest within 15 calendar days after termination of hospitalisation and this on the prescribed “Claim notification” form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company’s self service portal. **In case of belated claim notification, the insurance company is entitled to adequately decrease benefit payment and this by up to 50 %.** If the insured person is not able to notify the insurance company of the insured event himself/herself due to the severity of his/her health status in case of the daily allowance rider at hospital stay CHO1 or CHO4 and he/she is not even able to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event. In case of the daily allowance rider at a child’s hospital stay CHO2, the insured event is reported by the insured person or by his/her legal representative.
6. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium for rider at hospital stay due to accident CHU1 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges for the topical age of the insured person. Specific level of regular premium for the first insurance year of this rider, for which it is arranged at the time of increasing premium rate (so-called natural premium), is mentioned in the insurance contract for the first insurance year of the rider (or in the proposal for change in the insurance contract) and specific level of regular premium for each other insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written announcement to the policyholder latest 8 weeks before anniversary of the main coverage.
3. The amount of regular premium for rider at hospital stay due to accident CHU4 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges for the entire insurance period in dependence on the age of the insured person as of the rider’s start.
4. The amount of regular premium for rider at a child´s hospital stay due to accident CHUF is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges.

Table of natural rates CHU1			
Age	15-44	45-54	55-65
Rate (in CZK)	**5**	**6**	**7**

Article 4 - What period do I arrange the rider for?

1. The riders are arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **For child rider for case of hospitalisation due to an accident CHUF the right to benefit payment does not arise if the hospitalisation due to an accident occurred in direct or indirect connection with birth defects of insured child and/or injuries caused as a result thereof.**
2. **The right to benefit payment does not arise if the hospitalisation due to an accident occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **Mental disorder of the insured person;**
   d) **Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**
   e) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   f) **Radioactive, toxic, explosive or otherwise dangerous or**

contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;

g) Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;

h) Professional operation of a sport by the insured person;

i) Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them (this exception is valid only for daily allowance rider at hospital stay due to accident CHU1 and CHU4);

j) Accidents that occurred before the insurance start;

k) Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;

l) Worsening of the insured person's disease, which occurred due to the accident of the insured person;

m) Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations; all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);

n) Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.

3. **In addition, the right to benefit payment does not arise if:**
   a) It is about a curative stay of the insured person in sanatoriums, health spas, rehabilitation centres or rehabilitation departments of health care centres; this is not valid in case when the stay there represents a necessary part of the treatment of the insured person's accident from medical point of view and the insurance company expressed its prior written approval with this stay;
   b) It is about a curative stay of the insured person in treatment centres of alcoholism, drug or gaming addictions;
   c) It is about hospitalisation of the insured person in nursing homes for long-term care, in medical institutions for treatment of tuberculosis and respiratory diseases and in other professional health care institutions, special children's health care facilities, at the insured person's stay in institutes of social care and at army medical facilities;
   d) It is about hospitalisation of the insured person that is connected only with the need of nursing and day care no matter whether it is about partial hospitalisation with day or night treatment.

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider also automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do these rider concern?

1. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
2. If a period is set for a certain act in these SPC CHU1/CHU4 and CHUF and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
3. **The insurance company has the right to perform an adequate change in these SPC CHU1/CHU4 and CHUF and/or in the tariff of charges in case of the rise of a reasonable need for change (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CHU1/CHU4 and CHUF to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CHU1/CHU4 and CHUF to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CHU1/CHU4 and CHUF and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CHU1/CHU4 and CHUF and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

1. These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Daily allowance
Amount agreed in the insurance contract that is paid per day of the insured event's duration.

Hospitalisation
Provision of hospital in patient care to the insured person due to a disease or an accident of the insured person or in connection with delivery that is necessary from medical point of view and if it is hospitalisation due to a disease, which started on the territory of the Czech Republic during the period of the rider's duration at the same time; it is considered as necessary from medical point of view if the insured person's treatment must be performed in a hospital as in patient care due to the severity of the disease or due to the character of treatment.

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on the periods among the dates of the main coverage anniversaries following one after another.

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence)

is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University.

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Accident
Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

Special insurance conditions for insurance of the type SELECTED DIAGNOSES OF A CHILD RIDER CDN2

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for selected diagnoses of a child rider CDN2 (hereinafter only "SPC CDN2") create an integral part of the contract and are supplemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CDN2 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CDN2.
3. This rider may be arranged only as supplementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the rider and what benefit payment am I entitled to in case of insured event?

1. A disease of the insured person mentioned in Chart 1 of the Supplement to these SPC CDN2, which occurred after expiry of the waiting period according to Art. 5 paragraph 2 of these SPC, represents an insured event at the rider CDN2. In case of some diagnoses the benefit will be paid only when child was hospitalized due to this diagnosis or was vaccinated against it. These conditions are described in Chart 1 in the Supplement to these SPC CDN2.
2. In case of an insured event the insurance company will pay a single benefit corresponding to the sum assured mentioned in the relevant chart of the Supplement to these SPC CDN2 for the given disease and the arranged multiple of the sum assured.
3. **If more diseases (diagnoses) were diagnosed at the insured person during the insurance period at the same time, the insurance company pays the benefit for each disease according to Chart 1 in the Supplement to these SPC CDN2. If some of the diseases were diagnosed at the insured person during the insurance period repeatedly, the insurance company pays the benefit for each such insured event with exception of cases explicitly mentioned in Chart 1 in the Supplement to these SPC CDN2.**
4. **An insured event is reported to the seat of the insurance company without an unnecessary delay, and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's service portal. The insured event is reported by the insured person or by his/her legitimate representative. The insurance company will pay the benefit after the claim to benefit payment has been documented to it (the confirmation of a doctor about diagnosis of the diseases according to Chart 1 in the Supplement to these SPC, in case of some diseases according to Chart 1 in the Supplement to these SPC the vaccination certificate or the verified copy of the report from the hospital must be added and the properly completed Claim notification form have been submitted).
5. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods agreed in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is equal to the multiple of the arranged sum assured and the premium rate set in the tariff of charges.

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exclusions are arranged)?

1. **The right to benefit payment does not arise if the disease occurred in direct or indirect connection with:**
   a) **Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   b) **Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   c) **X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   d) **Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, transported, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   e) **Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent.**
2. **The right to benefit payment also does not arise if the day of the insured event's rise occurs before expiry of the waiting period of 3 months from the day of this rider's start.**
3. **If there is an insured event within the period of 3 months from the day when the sum assured of this rider was increased on the basis of the policyholder's request, the insurance company will decrease the benefit to the sum assured valid before its increase.**
4. **Other exclusions from benefit payment are set by relevant provisions of GTC.**

Article 6 - In what situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. **The policyholder or the insured person is obliged to notify the insurance company of all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data or circumstances that have an influence on existence of insurance interest.**
2. If a period is set for a certain act in these SPC CDN2 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
3. **The insurance company has the right to perform an adequate change in these SPC CDN2 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CDN2 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CDN2 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CDN2 and/or in the tariff of

charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CDN2 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms, which are not defined in this Article, have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Waiting period

Period, during which the obligation to provide benefit payment from events that would otherwise represent claims, does not arise to the insurance company.

Hospitalization

Provision of hospital in patient care to the insured person due to a disease of the insured person or in connection with delivery that is necessary from medical point of view and if it is hospitalisation due to a disease, which started during the period of the rider's duration at the same time; it is considered as necessary from medical point of view if the insured person's treatment must be performed in a hospital as in patient care due to the severity of the disease or due to the character of treatment; hospitalization lasts at least 24 hours.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF THE RIDER CDN2

Table 1: Diagnoses and corresponding sums assured for CDN2 cover

Diagnosis			Variant 1 000 to 2 000 CZK	Variant 2 000 to 4 000 CZK	Variant 3 000 to 6 000 CZK	The condition of entitlement to insurance benefits	To substantiate a claim it is required to add
001	A36	Diphtheria	1 000 CZK	2 000 CZK	3 000 CZK	vaccination	copy of the vaccination certificate
002	A37	Whooping cough	1 000 CZK	2 000 CZK	3 000 CZK	vaccination	copy of the vaccination certificate
003	B02	Zoster [herpes zoster]	1 000 CZK	2 000 CZK	3 000 CZK		
004	B05	Measles	1 000 CZK	2 000 CZK	3 000 CZK	vaccination	copy of the vaccination certificate
005	B06	Rubella [German measles]	1 000 CZK	2 000 CZK	3 000 CZK	vaccination	copy of the vaccination certificate
006	B26	Mumps	1 000 CZK	2 000 CZK	3 000 CZK	vaccination	copy of the vaccination certificate
007	B80	Enterobiasis	1 000 CZK	2 000 CZK	3 000 CZK		
008	B86	Scabies	1 000 CZK	2 000 CZK	3 000 CZK		
009	D69	Purpura and other haemorrhagic conditions	1 000 CZK	2 000 CZK	3 000 CZK		
010	E06	Thyroiditis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
011	H04	Disorders of lacrimal system	1 000 CZK	2 000 CZK	3 000 CZK		
012	H10	Conjunctivitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
013	H60	Otitis externa	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
014	H65	Nonsuppurative otitis media	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
015	H68	Eustachian salpingitis and obstruction	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
016	H92	Otalgia and effusion of ear	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
017	I83	Varicose veins of lower extremities	1 000 CZK	2 000 CZK	3 000 CZK	once for the duration only	
018	J00	Acute nasopharyngitis [common cold]	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
019	J01	Acute sinusitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
020	J02	Acute pharyngitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
021	J03	Acute tonsillitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
022	J04	Acute laryngitis and tracheitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
023	J20	Acute bronchitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
024	J21	Acute bronchiolitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
025	J41	Simple and mucopurulent chronic bronchitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
026	J45	Asthma	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
027	K40	Inguinal hernia	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
028	K41	Femoral hernia	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital

029	K42	Umbilical hernia	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
030	K43	Ventral hernia	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
031	K44	Diaphragmatic hernia	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
032	K65	Peritonitis	1 000 CZK	2 000 CZK	3 000 CZK		
033	K81	Cholecystitis	1 000 CZK	2 000 CZK	3 000 CZK		
034	L02	Cutaneous abscess, furuncle and carbuncle	1 000 CZK	2 000 CZK	3 000 CZK		
035	L03	Cellulitis	1 000 CZK	2 000 CZK	3 000 CZK		
036	L04	Acute lymphadenitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
037	L05	Pilonidal cyst	1 000 CZK	2 000 CZK	3 000 CZK		
038	N20	Calculus of kidney and ureter	1 000 CZK	2 000 CZK	3 000 CZK		
039	N30	Cystitis	1 000 CZK	2 000 CZK	3 000 CZK	hospitalization	verified copy of the report from the hospital
040	N47	Redundant prepuce, phimosis and paraphimosis	1 000 CZK	2 000 CZK	3 000 CZK		
041	P38	Omphalitis of newborn with or without mild haemorrhage	1 000 CZK	2 000 CZK	3 000 CZK		
042	P51	Umbilical haemorrhage of newborn	1 000 CZK	2 000 CZK	3 000 CZK		
043	A01	Typhoid and paratyphoid fevers	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
044	B27	Infectious mononucleosis	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
045	B30	Viral conjunctivitis	1 500 CZK	3 000 CZK	4 500 CZK		
046	E10	Insulin-dependent diabetes mellitus	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
047	G50	Disorders of trigeminal nerve	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
048	G51	Facial nerve disorders	1 500 CZK	3 000 CZK	4 500 CZK		
049	H16	Keratitis	1 500 CZK	3 000 CZK	4 500 CZK		
050	H20	Iridocyclitis	1 500 CZK	3 000 CZK	4 500 CZK		
051	H30	Chorioretinal inflammation	1 500 CZK	3 000 CZK	4 500 CZK		
052	H40	Glaucoma	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
053	H46	Optic neuritis	1 500 CZK	3 000 CZK	4 500 CZK		
054	H66	Suppurative and unspecified otitis media	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
055	I30	Acute pericarditis	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
056	I80	Phlebitis and thrombophlebitis	1 500 CZK	3 000 CZK	4 500 CZK		
057	I85	Oesophageal varices	1 500 CZK	3 000 CZK	4 500 CZK		
058	I88	Nonspecific lymphadenitis	1 500 CZK	3 000 CZK	4 500 CZK		
059	J09	Influenza due to certain identified influenza virus	1 500 CZK	3 000 CZK	4 500 CZK		
060	J15	Bacterial pneumonia, not elsewhere classified	1 500 CZK	3 000 CZK	4 500 CZK		
061	J47	Bronchiectasis	1 500 CZK	3 000 CZK	4 500 CZK		
062	K20	Oesophagitis	1 500 CZK	3 000 CZK	4 500 CZK		
063	K21	Gastro-oesophageal reflux disease	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
064	K29	Gastritis and duodenitis	1 500 CZK	3 000 CZK	4 500 CZK		
065	K35	Acute appendicitis	1 500 CZK	3 000 CZK	4 500 CZK		
066	K50	Crohn disease [regional enteritis]	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
067	K51	Ulcerative colitis	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
068	K80	Cholelithiasis	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
069	K85	Acute pancreatitis	1 500 CZK	3 000 CZK	4 500 CZK		
070	L40	Psoriasis	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
071	L90	Atrophic disorders of skin	1 500 CZK	3 000 CZK	4 500 CZK		
072	M87	Osteonecrosis	1 500 CZK	3 000 CZK	4 500 CZK		
073	N44	Torsion of testis	1 500 CZK	3 000 CZK	4 500 CZK		
074	N45	Orchitis and epididymitis	1 500 CZK	3 000 CZK	4 500 CZK		

075	N70	Salpingitis and oophoritis	1 500 CZK	3 000 CZK	4 500 CZK		
076	Q53	Undescended testicle	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
077	R01	Cardiac murmurs and other cardiac sounds	1 500 CZK	3 000 CZK	4 500 CZK	once for the duration only	
078	R04	Haemorrhage from respiratory passages	1 500 CZK	3 000 CZK	4 500 CZK	hospitalization	verified copy of the report from the hospital
079	A38	Scarlet fever	2 000 CZK	4 000 CZK	6 000 CZK		
080	A39	Meningococcal infection	2 000 CZK	4 000 CZK	6 000 CZK		
081	A40	Streptococcal sepsis	2 000 CZK	4 000 CZK	6 000 CZK		
082	A82	Rabies	2 000 CZK	4 000 CZK	6 000 CZK		
083	A84	Tick-borne viral encephalitis	2 000 CZK	4 000 CZK	6 000 CZK		
084	A87	Viral meningitis	2 000 CZK	4 000 CZK	6 000 CZK		
085	B25	Cytomegaloviral disease	2 000 CZK	4 000 CZK	6 000 CZK		
086	E84	Cystic fibrosis	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
087	G00	Bacterial meningitis	2 000 CZK	4 000 CZK	6 000 CZK		
088	G04	Encephalitis, myelitis and encephalomyelitis	2 000 CZK	4 000 CZK	6 000 CZK		
089	G35	Multiple sclerosis	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
090	H70	Mastoiditis and related conditions	2 000 CZK	4 000 CZK	6 000 CZK		
091	I20	Angina pectoris	2 000 CZK	4 000 CZK	6 000 CZK		
092	I21	Acute myocardial infarction	2 000 CZK	4 000 CZK	6 000 CZK		
093	I25	Chronic ischaemic heart disease	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
094	I26	Pulmonary embolism	2 000 CZK	4 000 CZK	6 000 CZK		
095	I40	Acute myocarditis	2 000 CZK	4 000 CZK	6 000 CZK		
096	I42	Cardiomyopathy	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
097	I47	Paroxysmal tachycardia	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
098	J05	Acute obstructive laryngitis [croup] and epiglottitis	2 000 CZK	4 000 CZK	6 000 CZK		
099	J13	Pneumonia due to Streptococcus pneumoniae	2 000 CZK	4 000 CZK	6 000 CZK		
100	J18	Pneumonia, organism unspecified	2 000 CZK	4 000 CZK	6 000 CZK	hospitalization	verified copy of the report from the hospital
101	J36	Peritonsillar abscess	2 000 CZK	4 000 CZK	6 000 CZK		
102	J93	Pneumothorax	2 000 CZK	4 000 CZK	6 000 CZK		
103	J96	Respiratory failure	2 000 CZK	4 000 CZK	6 000 CZK		
104	K56	Paralytic ileus and intestinal obstruction without hernia	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
105	K90	Intestinal malabsorption	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
106	M00	Pyogenic arthritis	2 000 CZK	4 000 CZK	6 000 CZK		
107	M08	Juvenile arthritis	2 000 CZK	4 000 CZK	6 000 CZK		
108	M86	Osteomyelitis	2 000 CZK	4 000 CZK	6 000 CZK		
109	N00	Acute nephritic syndrome	2 000 CZK	4 000 CZK	6 000 CZK		
110	N04	Nephrotic syndrome	2 000 CZK	4 000 CZK	6 000 CZK	once for the duration only	
111	N10	Acute tubulo-interstitial nephritis	2 000 CZK	4 000 CZK	6 000 CZK		
112	N13	Obstructive and reflux uropathy	2 000 CZK	4 000 CZK	6 000 CZK		
113	N17	Acute renal failure	2 000 CZK	4 000 CZK	6 000 CZK		
114	N34	Urethritis and urethral syndrome	2 000 CZK	4 000 CZK	6 000 CZK	hospitalization	verified copy of the report from the hospital

Special insurance conditions for insurance of the type
RIDER AT SICK LEAVE DUE TO ACCIDENT OR DISEASE CPN5
RIDER AT SICK LEAVE DUE TO ACCIDENT OR DISEASE CPN6

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for rider at sick leave due to accident or disease CPN5 and for rider at sick leave due to accident or disease CPN6 (hereinafter only "SPC CPN5/CPN6") create an integral part of the insurance contract and are complemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CPN5/CPN6 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CPN5/ CPN6.
3. These riders can be arranged only as complementary insurance to the main life insurance (hereinafter only the "Main coverage"). **Rider at sick leave due to accident or disease CPN5 and rider at sick leave due to accident or disease CPN6 cannot be arranged concurrently.** Unless explicitly mentioned otherwise further in these SPC CPN5/ CPN6, any of the two riders CPN5/CPN6 is understood by the term rider (in singular).
4. **If provisions about anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event within this rider is sick leave of the insured person due to accident or disease (hereinafter "sick leave")**.
2. **Sick leave of the insured person, which occurred before expiry of the waiting period of 3 months since the rider's start due a disease, does not represent an insured event. This waiting period is prolonged to 8 months in case of sick leave in connection with pregnancy.**
3. Benefit payment is provided from the 29th day of lasting sick leave acknowledged by a doctor (further also only the **"Start of benefit payment"**).
4. Insurance benefit shall be provided until the end of the sick leave. The end of the sick leave may be determined by a doctor or a health-care institution selected by an insurance company. In order to determine the end of the sick leave, the doctor or a health-care institution shall issue a medical certificate based on an examination in accordance with Article 7 paragraph 2 and 3 of these SPC. Alternatively, the end of the sick leave is determined by Supplement to these SPC CPN5/CPN6, Table 1, that provides the maximum duration of an insurance benefit based on particular diagnosis (hereinafter only "**insurance benefit termination"**).
5. Insurance benefit is determined as the product of the agreed daily allowance and the number of days between the beginning of the provision of insurance benefit and its termination.
6. In case of the second and subsequent sick leave that is based on the same reason, illness, or injury as the first one, and within 4 weeks since the first insurance benefit termination, insurance benefit shall be provided as of the first day of the second and subsequent sick leave. The provision of insurance benefit, hence, is not postponed.
7. **If the break between sick leaves due to the same disease or accident is shorter than 6 months, then these periods of sick leaves are added up for determination of the benefit payment duration (i.e. the maximum period of benefit payment is applied in the summary of all such sick leaves, not for each sick leave separately).** If sick leave is acknowledged due to more diseases or injuries concurrently, the daily allowance from rider is paid only once. In case of the subsequent sick leave based on not-identical causes, the daily allowance is provided up to 365 days.
8. **An insured event is reported to the seat of the insurance company without an unnecessary delay, however, latest as of the 59th day of lasting sick leave acknowledged by a doctor and this on the prescribed "Claim notification" form of the insurance company,** which is available at the websites of the insurance company or in the environment of the insurance company's self service portal.
9. **If the health status of the insured person does not prevent early notification of the insured event and the insured event has been reported belatedly only after the 59th day of lasting sick leave, the insurance company is obliged to pay the benefit only for the period from the day when it received the claim notification. If the health status of the insured person does not prevent early notification of the insured event and the insured event is reported only after termination of sick leave, the insurance company is not obliged to pay the benefit at all. If the health status of the insured person prevents claim notification, the insured event must be reported latest within 15 calendar days after this obstacle has disappeared.**
10. If the insured person is not able to notify the insurance company of the insured event with regard to the severity of his/her health status and he/she is not even able to ask for benefit payment, also the policyholder, a person closed to the insured or sharing a common household with him/her or another person that has a legal interest in benefit payment, is entitled to report the insured event. In such a case the benefit will be paid in favour of a bank account arranged for these purposes in the insurance contract unless the insured person determines otherwise within investigation of the insured event.
11. **The insurance company will pay also a special bonus on the level of 25 % from the arranged daily allowance for the first 28 days of lasting sick leave acknowledged by a doctor to the arranged benefit if the insured event is reported latest by the day arranged as start of fulfilment (including).** This bonus is paid above the scope of the maximum period of benefit payment according to paragraph 6 of this Article, which means that the mentioned first 28 days of sick leave are not included in the maximum period of benefit payment in such a case. A claim to this bonus does not arise at notification of second and further sick leave due to the same disease or injury.
12. After the claim notification the insurance company will pay the benefit to the insured person once a month at the most but always only after the insured person has proven his/her lasting claim to benefit payment that means his/her sick leave continues. The claim is proven on the prescribed form of the insurance company, always with updated confirmation by a doctor.
13. The insured person is obliged to notify the insurance company of sick leave termination within 3 working days from the day when this fact occurred.
14. **The rider does not lapse by an insured event.**

Article 3 - When should I pay premium and in what amount?

1. Premium is set as regular with insurance periods arranged in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium for rider at sick leave due to accident or disease CPN5 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges of the insured person's actual age. For this rider is arranged at the time increasing premium rate (so-called natural premium), specific level of regular premium for the first year of the rider´s duration is mentioned in the insurance contract (or in the proposal for change in the insurance contract) and specific level of regular premium for each other insurance year will be announced to the policyholder in writing sufficiently in advance; the insurance company will send this written notification to the policyholder latest 8 weeks before the anniversary of the main coverage.
3. The amount of regular premium for rider at sick leave due to accident or disease CPN6 is equal to a multiple of the daily allowance for this rider and the premium rate set in the tariff of charges for the entire period of the rider's duration in dependence on the insured person's actual age as of the rider's start and on the duration of the period from the rider's start until the anniversary day of the main coverage in the calendar year, in which the insured person achieves the maximum age for this rider determined in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally).
4. Premium rates for this rider mentioned in the tariff of charges were set i.a. on the basis of (i) publicly available statistics about occurrence of diseases in the population issued by the relevant state authorities, private or professional organisations in the Czech Republic or in the EU (e.g. the Czech Statistical Office, the Institute of Health Information and Statistics of the Czech Republic, the Czech National Bank, the Czech Social Security Administration, the National Institute of Public Health, health insurance companies); (ii) the current status of medical knowledge and the ability to diagnose and heal the diseases; (iii) on the basis of current legal regulation for judgement of conditions and degrees. If in the future there are (i) indispensable changes in these statistics, or (ii) progress in medicine

leading to increase in the ability to diagnose and heal the diseases, or (iii) indispensable change in legal regulations for judgement of disability conditions and degrees, the insurance company is entitled to adequately increase premium rates for further insurance periods. The insurance company will publish the new premium rates by issuance of a new wording of the tariff of charges by the procedure according to Art. 7 paragraph 8 of these SPC CPN5/CPN6.

Table of natural rates CPN5						
Age	18-40	41-45	46-50	51-55	56-60	61-65
Rate (in CZK)	**70**	**80**	**90**	**110**	**130**	**145**

Article 4 - What period do I arrange the rider for?

1. The riders are arranged for the duration of cover mentioned in the insurance contract.

Article 5 – Which cases does the rider not relate to (what exceptions are arranged)?

1. **The right to benefit payment does not arise if it is sick leave acknowledged by a doctor for the following diseases according to the International Statistical Classification of Diseases:**
   - **a) back pain and spine disease, their causes, consequences and complications (diagnosis M40-M54)**
   - **b) nerve roots and plexus disorders and compression (diagnoses G54 and G55)**
   - **c) infertility (diagnosis N46, N97)**
   - **d) endometriosis (diagnosis N80)**
   - **e) complications associated with artificial fertilization (diagnosis N98)**
2. **The right to benefit payment does not arise if sick leave occurred in direct or indirect connection with:**
   - **a) Suicide of the insured person, an attempt for it or at intentional self-inflicted trauma of the insured person including intentional not searching medical care or intentional disregard of medical instructions and this regardless of the topical state of mind of the insured person;**
   - **b) Diagnostic, research, cosmetic, therapeutic or preventive intervention, which the insured person performs or lets be done and which is not necessary from medical point of view including all interventions not prescribed by a doctor;**
   - **c) Mental disorder of the insured person;**
   - **d) Disorder or loss of consciousness of the insured person, epileptic seizure or other convulsion, which affects the whole body of the insured person unless the accident was their exclusive cause;**
   - **e) X-ray, ionizing or nuclear radiation that was caused by an explosion or defect of facilities and equipment, by unprofessional treatment of persons, radioactive contamination by any nuclear fuel or nuclear waste, or combustion of nuclear fuel;**
   - **f) Radioactive, toxic, explosive or otherwise dangerous or contaminating feature of any nuclear facility, radioactive material, reactor, nuclear assembly or nuclear component. As regards radioactive material this exclusion does not relate to radioactive isotopes other than nuclear fuel if these isotopes are prepared, kept or used for commercial, agricultural, medical, scientific or other similar peaceful purposes;**
   - **g) Effect of chemical, biological, bio-chemical, electromagnetic weapons or effect of weapons or facilities using atomic or nuclear fissure, synthesis or another similar reaction, radioactive power or agent;**
   - **h) Professional operation of a sport by the insured person;**
   - **i) Performance of works by the insured person that are forbidden by labour-law regulations and regulations connected with them;**
   - **j) Disease or accidents that occurred before the insurance start with exception of cases when a health care questionnaire was completed at the conclusion of the contract, this questionnaire was completed truthfully and completely and the insurance company accepted the insured person for insurance despite of the existence of the mentioned disease;**
   - **k) Accident of the insured person occurred in connection with any of his/her diseases including worsening of the disease or in connection with chronic health complications existing before such an accident;**
   - **l) Worsening of the insured person's disease, which occurred due to the accident of the insured person;**
   - **m) Accident of the insured person arisen at operation of sports by the insured person and this extremely risky sports or sports operated in extreme conditions and/or requiring special technical equipment (such as e.g. mountain climbing and alpinism above 3,000 m above sea level; instrument scuba diving into the depth of more than 40 m and cave diving, diving to shipwrecks and under ice; races of all motor vehicles including preparatory examinations, all aviation sports and flights by other aircrafts than those of licenced airline operators; adrenalin sports of hazardous nature, i.e. such ones that are operated without usual safeguarding or in other than usual conditions – e.g. climbing without safeguarding by rope, skiing out of slopes, cycling out of marked trails);**
   - **n) Accident of the insured person arisen at aviation under the condition that the insured person is a flight participant and it is not an officially registered regular or charter flight operated by a licenced airline operator.**

Exclusions mentioned in this paragraph under letters d), h), k) – n) are valid only in case that it is about sick leave due to the accident.

3. **In addition to this, the right to benefit payment does not arise if:**
   - **a) The sick leave of the insured person – a woman occurs due to Caesarian delivery of her child or due to artificial interruption of her pregnancy because of a different than health indication;**
   - **b) The sick leave due to a disease is connected with a stay of the insured person in sanatoriums, health spas, rehabilitation centres or rehabilitation departments of health care centres; this is not valid in case when the stay there represents a necessary part of the insured person's treatment from medical point of view and the insurance company expressed its prior written approval with this stay;**
   - **c) The sick leave due to a disease is connected with a stay of the insured person in treatment centres of alcoholism, drug or gaming addictions;**
   - **d) The insured person does not stay at the domicile, which he/she mentioned for these purposes, during the sick leave (this is not valid if he/she undergoes a hospital treatment necessary from medical point of view or if he/she left his/her domicile with the written approval of the attending physician) and/or if the insured person receives maternity allowance, parental contribution or state unemployment benefit.**
4. **The insurance company is entitled to decrease benefit payment if it finds out that the insured person did not keep instructions of the doctor or the patient regime during the sick leave.** The insurance company will decrease benefit payment in dependence on the level, by which violation of these obligations contributed to continuation of the sick leave.
5. **Physiological delivery and infertility are considered neither as a disease nor as an injury, which means there is no claim to benefit payment at sick leave due to these reasons.**
6. **If a sick leave occurs due to a disease within the period of 3 months from the day when the arranged daily allowance to this rider was increased on the basis of the policyholder's request, the insurance company will decrease benefit payment to the lowest daily allowance valid for the last 3 months before the day of the rise of this insured event; if the insured event is sick leave in connection with a pregnancy, the period mentioned in the previous sentence is prolonged to 8 months.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do these rider concern?

1. The insurance company examines the health status of the insured person at the arrangement of this rider for the purpose of insurance risk and premium level determination. The insurance company examines the health status of the insured person especially on the basis of the health status questionnaire, which the insured person is obliged to fill in truthfully and completely at the arrangement of this rider (unless exceptionally set otherwise by the insurance company) and possibly also on the basis of reports and medical records requested from the attending physician of the insured person or a specialist doctor by the insurance company or by a health centre entrusted by it.

   Upon the request by the insurance company the insured person is also obliged to undergo a medical examination or examination by a doctor or

health centre determined by the insurance company, i.e. in justified cases the insurance company is entitled to check the insured person's health status including his/her working ability by a doctor appointed by itself. On the basis of these findings the insurance company will confirm arrangement of this rider without a change, propose its change (present a counter-proposal) or it will terminate the rider with regard to the insured person's health status.

2. **The insurance company also reserves the right to similarly examine the health status of the insured person at the time of the sick leave duration that was reported as an insured event. Should the insured person deny undergoing an examination by a doctor or health centre determined by the insurance company for the purpose to examine the health status and working ability of the insured person in this connection within the set adequate period upon the request of the insurance company, the insurance company is entitled to deny benefit payment. At the same time it is also valid for an insured person who is not an employee (i.e. who performs self-employed activity) that if the doctor or health centre appointed for this judges within examination of the health status and the working ability of the insured person that health reasons for sick leave have already subsided and the sick leave of the insured person should be terminated by a doctor's decision, the insurance company will terminate benefit payment.**
3. **If is the sick leave of the insured person unreasonable for the diagnosis that is not listed in Table 1 of the annex to these SPC CPN5/CPN6 and this extension is not in the medical documentation technically justified, the insurer is entitled to determine the benefit payment after consultation with a doctor contracted by the normal length of incapacity for the diagnosis. The maximum level of daily allowance, which can be arranged, is limited by the amount of gross annual income of the insured person as of the day of the rider's arrangement according to the Table 2 of the Supplement to these SPC CPN5/CPN6. The insurance company has the right to verify the insured person's income at an insured event. The income is proven by a confirmation from the payer of salary about the insured person's income as an employee for the period of 3 calendar months following one after another antecedent to the day of the rider's start and if the insured person is not an employee, the income is proven by a certified copy of the tax return for the last taxation period antecedent to the day of the rider's start.**
4. **The policyholder or the insured person is obliged to inform the insurance company about all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on the existence of the insurance interest.**
5. The insured person is obliged to notify the insurance company of each change concerning his/her employment or self-employed activity without an unnecessary delay especially if it is about change in work position, employment or subject of self-employed activity or loss of employment or termination/interruption of self-employed activity and subsequent start of new employment or self-employed activity including further changes influencing the insured person's level of income.
6. **The rider of sick leave is interrupted starting by the day when the insured person is neither employed nor performs a self-employed activity and the interruption lasts up until the day, as of which the insured person is employed again or starts to perform self-employed activity again**. Insurance coverage is not provided to the insured person during the rider's interruption and the policyholder is not obliged to pay premium for the given rider. If premium has been already paid for the period of insurance interruption, the insurance company will return the premium paid for the period of insurance interruption to the policyholder.
7. If a period is set for a certain act in these SPC CPN5 and CPN6 and/or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
8. **The insurance company has the right to perform an adequate change in these SPC CPN5 and CPN6 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CPN5 and CPN6 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.**
   The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CPN5 and CPN6 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CPN5 and CPN6 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice period represents 20 calendar days from the day of the written notice delivery.
   If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CPN5 and CPN6 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.

Article 8 - When are these special insurance conditions effective from?

1. These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – what terms are important for me?

Terms not defined in this Article have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims, does not arise to the insurance company.

Daily allowance
Amount agreed in the insurance contract that is paid per day of the insured event's duration.

Gross income
Amount corresponding to the gross salary (if it is an employee) and/or income from business activity or from another independent gainful activity after deduction of expenditures according to the tax return for the past taxation period (if it is not an employee).

Insurance year
Period of twelve months following from the insurance start (main coverage) until the date of the first anniversary of the main coverage and further on the periods among the dates of the main coverage anniversaries following one after another.

Sick leave
Sick leave of the insured person identified by a doctor (including issuance of the sick leave document by the relevant doctor) caused by a disease or an accident of the insured person, which started at the time of the rider's duration, is necessary from medical point of view, was acknowledged in compliance with legal regulations of the Czech Republic; in case of sick leave the insured person cannot perform and also does not perform his/her employment or self-employed activity according to a doctor's decision in any way and this even for a limited part of a day and he/she also does not perform management or control activity.

Professional operation of sport
Sports activity performed as profession on the basis of a contract concluded with a sports club or another entity doing business in this area if it is obvious from such a contract that the sportsman/sportswoman gains financial means for satisfaction of his/her needs (usually it is his/her main or prevailing source of income) by performance of the sports activity (in the form of races, competitions, including preparation for them); also operation of fully contact sports and sports activity within the highest national senior competition in the relevant type of sport (regardless of the contract's content or existence) is understood as professional operation of sport and this also in case if the sportsman/sportswoman performs also a profession next to the sports activity or he/she permanently prepares himself/herself for performance of his/her future profession by studies at a secondary school or at a University.

Tariff of charges

The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

Accident

Unexpected and sudden effect of one's force or external forces independently of the will of the insured that occurred during the period of the rider's duration and that resulted in the insured sustaining damage to his/her health or in his/her death, the external forces being also understood as uninterrupted action of high or low temperatures, gases, vapours, radiation, electric current, chemical substances and venoms (with the exception of microbial venoms and immunotoxic substances); an insured event is regarded to have been caused by accident also in cases when such event has occurred as a result of a disease that occurred exclusively as a result of accident or local festering following the penetration of pathogenic germs in the form of HIV virus or of tetanus bacteria into an open wound caused by accident. Accidents, on the other hand, are not the following: synovitis, epicondylitis, inguinal and umbilical hernia, spinal disk herniation and complaints relating to this, including vertebrogennic pain syndrome, not excluding those cases where these conditions have been caused by accident and bodily harms due to overloading when lifting heavy burden.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF THE RIDERS CPN5 AND CPN6

Table 1: The maximum benefit period for selected diagnosis

Diagnosis by ICD	Diagnosis name	Maximum benefit period
G40-G47	Episodic and paroxysmal disorders	30 days
G50-G53; G56-G59	Nerve, nerve root and plexus disorders	90 days
J00-J06	Diseases of the respiratory system	30 days
J09-J18	Influenza and pneumonia	30 days
J20-J22	Other acute lower respiratory infections	30 days
J30-J39	Other diseases of upper respiratory tract	30 days
J40-J47	Chronic lower respiratory diseases	30 days
J60-J70	Lung diseases due to external agents	30 days
M00-M03	Infectious arthropathies	90 days
M05-M14	Inflammatory polyarthropathies	90 days
M15-M19	Osteoarthritis	120 days
M20-M25	Other joint disorders	90 days
M65-M68	Disorders of synovium and tendon	90 days
M70-M73	Other soft tissue disorders	90 days
O00-O99	Pregnancy, childbirth and the puerperium	21 days
S06.0	Concussion	28 days
S13.4-S13.6	Dislocation and sprain of joints and ligaments at neck level	14 days
S20	Superficial injury of thorax	10 days
S30	Superficial injury of abdomen, lower back and pelvis	10 days
S40	Contusion of shoulder and upper arm	10 days
S43.1-S43.7	Dislocation and sprain of joints and ligaments of shoulder girdle	21 days
S50	Superficial injury of elbow and forearm	10 days
S63	Dislocation and sprain of joints and ligaments at wrist and hand level	21 days
S66	Injury of muscle, fascia and tendon at wrist and hand level	50 days
S80	Contusion of unspecified knee	21 days
S83	Dislocation and sprain of joints and ligaments of knee	42 days
S93.4-S93.6	Dislocation and sprain of joints and ligaments at ankle, foot and toe level	21 days
Z35	Supervision of high-risk pregnancy	21 days
	Other injuries and diseases (excluding exceptions)	356 days

Table 2: The maximum level of daily allowance

Gross income	The maximum level of daily allowance		
	Employee	**Self-employer with insurance**	**Self-employer without insurance**
until 339 999 CZK	300 CZK	500 CZK	500 CZK
340 0000-359 999 CZK	300 CZK	500 CZK	530 CZK
360 0000-379 999 CZK	300 CZK	500 CZK	560 CZK
380 0000-399 999 CZK	300 CZK	500 CZK	590CZK
400 000-419 999 CZK	300 CZK	500 CZK	610 CZK
420 000-439 999 CZK	300 CZK	500 CZK	640 CZK
440 000-459 999 CZK	300 CZK	500 CZK	670 CZK
460 000-479 999 CZK	300 CZK	500 CZK	700 CZK
480 000-499 999 CZK	300 CZK	500 CZK	720 CZK
500 000-519 999 CZK	310 CZK	500 CZK	750 CZK
520 000-539 999 CZK	330 CZK	500 CZK	780 CZK
540 000-559 999 CZK	360 CZK	500 CZK	810 CZK
560 000-579 999 CZK	380 CZK	500 CZK	840 CZK
580 000-599 999 CZK	410 CZK	500 CZK	860 CZK
600 000-619 999 CZK	430 CZK	500 CZK	890 CZK
620 000-639 999 CZK	450 CZK	500 CZK	920 CZK
640 000-659 999 CZK	480 CZK	500 CZK	950 CZK
660 000-679 999 CZK	500 CZK	500 CZK	980 CZK
680 000-699 999 CZK	530 CZK	500 CZK	1000 CZK
700 000-719 999 CZK	550 CZK	500 CZK	1030 CZK
720 000-739 999 CZK	570 CZK	500 CZK	1060 CZK
740 000-759 999 CZK	600 CZK	500 CZK	1090 CZK
760 000-779 999 CZK	620 CZK	500 CZK	1110 CZK
780 000-799 999 CZK	650 CZK	500 CZK	1140 CZK
800 000-819 999 CZK	670 CZK	500 CZK	1170 CZK
820 000-839 999 CZK	690 CZK	500 CZK	1200 CZK
840 000-859 999 CZK	720 CZK	500 CZK	1230 CZK
860 000-879 999 CZK	740 CZK	500 CZK	1250 CZK
880 000-899 999 CZK	770 CZK	500 CZK	1280 CZK
900 000-919 999 CZK	810 CZK	530 CZK	1310 CZK
920 000-939 999 CZK	840 CZK	560 CZK	1340 CZK
940 000-959 999 CZK	880 CZK	580 CZK	1370 CZK
960 000-979 999 CZK	910 CZK	610 CZK	1390 CZK
980 000-999 999 CZK	940 CZK	640 CZK	1420 CZK
1 000 000-1 019 999 CZK	980 CZK	670 CZK	1450 CZK
1 020 000-1 019 999 CZK	1010 CZK	700 CZK	1480 CZK
1 040 000-1 059 999 CZK	1050 CZK	720 CZK	1510 CZK
1 060 000-1 079 999 CZK	1080 CZK	750 CZK	1530 CZK
1 080 000-1 099 999 CZK	1110 CZK	780 CZK	1560 CZK
1 100 000- 1 119 999 CZK	1150 CZK	810 CZK	1590 CZK
1 120 000-1 139 999 CZK	1180 CZK	830 CZK	1620 CZK
1 140 000-1 159 999 CZK	1220 CZK	860 CZK	1650 CZK
1 160 000-1 179 999 CZK	1250 CZK	890 CZK	1670 CZK
1 180 000-1 199 999 CZK	1280 CZK	920 CZK	1700 CZK
1 200 000-1 219 999 CZK	1320 CZK	950 CZK	1730 CZK
1 220 000-1 239 999 CZK	1350 CZK	970 CZK	1760 CZK
1 240 000-1 259 999 CZK	1390 CZK	1000 CZK	1780 CZK
1 260 000-1 279 999 CZK	1420 CZK	1030 CZK	1810 CZK
1 280 000-1 299 999 CZK	1450 CZK	1060 CZK	1840 CZK
1 300 000-1 319 999 CZK	1490 CZK	1090 CZK	1870 CZK
1 320 000-1 339 999 CZK	1520 CZK	1110 CZK	1900 CZK
1 340 000-1 359 999 CZK	1550 CZK	1140 CZK	1920 CZK
1 360 000-1 379 999 CZK	1590 CZK	1170 CZK	1950 CZK
1 380 000-1 399 999 CZK	1620 CZK	1200 CZK	1980 CZK
1 400 000-1 419 999 CZK	1660 CZK	1220 CZK	2000 CZK
1 420 000-1 439 999 CZK	1690 CZK	1250 CZK	2000 CZK
1 440 000-1 459 999 CZK	1720 CZK	1280 CZK	2000 CZK
1 460 000-1 479 999 CZK	1760 CZK	1310 CZK	2000 CZK
1 480 000-1 499 999 CZK	1790 CZK	1340 CZK	2000 CZK
1 500 000-1 519 999 CZK	1830 CZK	1360 CZK	2000 CZK
1 520 000-1 519 999 CZK	1860 CZK	1390 CZK	2000 CZK
1 540 000-1 559 999 CZK	1900 CZK	1420 CZK	2000 CZK
1 560 000-1 579 999 CZK	1930 CZK	1450 CZK	2000 CZK
1 580 000-1 599 999 CZK	1960 CZK	1480 CZK	2000 CZK
1 600 000-1 619 999 CZK	2000 CZK	1500 CZK	2000 CZK
1 620 000-1 639 999 CZK	2000 CZK	1530 CZK	2000 CZK
1 640 000-1 659 999 CZK	2000 CZK	1560 CZK	2000 CZK
1 660 000-1 679 999 CZK	2000 CZK	1590 CZK	2000 CZK
1 680 000-1 699 999 CZK	2000 CZK	1620 CZK	2000 CZK
1 700 000-1 719 999 CZK	2000 CZK	1640 CZK	2000 CZK
1 720 000-1 739 999 CZK	2000 CZK	1670 CZK	2000 CZK
1 740 000-1 759 999 CZK	2000 CZK	1700 CZK	2000 CZK
1 760 000-1 779 999 CZK	2000 CZK	1730 CZK	2000 CZK
1 780 000-1 799 999 CZK	2000 CZK	1760 CZK	2000 CZK
1 800 000-1 819 999 CZK	2000 CZK	1780 CZK	2000 CZK
1 820 000-1 839 999 CZK	2000 CZK	1810 CZK	2000 CZK
1 840 000-1 859 999 CZK	2000 CZK	1840 CZK	2000 CZK
1 860 000-1 879 999 CZK	2000 CZK	1870 CZK	2000 CZK
1 880 000-1 899 999 CZK	2000 CZK	1890 CZK	2000 CZK
1 900 000-1 919 999 CZK	2000 CZK	1920 CZK	2000 CZK
1 920 000-1 939 999 CZK	2000 CZK	1950 CZK	2000 CZK
1 940 000-1 959 999 CZK	2000 CZK	1980 CZK	2000 CZK
from 1 960 000	2000 CZK	2000 CZK	2000 CZK

Special insurance conditions for insurance of the type
ASSISTANCE SERVICES RIDER CAS4

Article 1 - Which legal documents are important for me and how to use them?

1. These special insurance conditions for assistance services rider CAS4 (hereinafter only "SPC CAS4") create an integral part of the contract and are supplemented by general insurance conditions of the insurance company for life insurance (hereinafter only "GTC").
2. Provisions of these SPC CAS4 are superior to GTC; then specific provisions in the insurance contract are superior to these SPC CAS4.
3. These riders may be arranged only as supplementary insurance to the main life insurance (hereinafter only the "Main coverage").
4. **If provisions about the anti-inflation programme and about the possibility to increase the sum assured without examination of the health status are mentioned in GTC, then they do not relate to this rider.**

Article 2 - What is covered by the riders and what benefit payment am I entitled to in case of insured event?

1. **An insured event is an assistance event that means an accident or a disease, which occur at the time of this rider's duration and require assistance benefit in the form of assistance services on the territory of the Czech Republic, which the insured person is not able to manage himself/herself as a result of the insured event in the sense of Art. 2 paragraph 3 of these SPC. However, this only under the condition that this insured event occurred at the insured person only after expiry of the waiting period of 1 week from the day of this rider's start.**
2. An overview of assistance benefits and the arranged financial limits for assistance benefits are mentioned in the Supplement to these SPC CAS4. Assistance benefit is provided with a limit or without a limit depending on the type of assistance services. **The upper financial limit for assistance benefits for all assistance events limited by the limit occurred in connection with one insured person during a year or per assistance event is the total annual limit for assistance benefit.**
3. In case of an insured event, the assistance company will provide assistance benefit in the scope of the following assistance services to the insured person, and this up to the amount of assistance benefit limits mentioned in the Supplement to these SPC CAS4 or without such a limit according to the rules mentioned in the Supplement if appropriate:
   a) Health information telephone line (telephone information from the area of prevention, general health information, proposal for usual course of actions when solving a health problem, telephone consultation of the course of treatment, health information telephone line, pharmaceutical information telephone line, home assistance information telephone line),
   b) Consultation of a health problem with a doctor per telephone. Health problems that may be consulted with the doctors can concern only general medicine, in case that the insured person wants to consult a problem from other medical areas (e.g. surgery, carcinology, opthalmology and the like), he/she has to address his/her attending physician. Consultations are provided only on general level and it is not possible to deduce any particular recommendation from them as regards a diagnosis or way of treatment. This can be judged only by the attending physician of the insured person on the basis of a thorough examination.
   c) Transport of the insured person to and from an examination or treatment at a doctor, and this in dependence on the health status of the insured person either in the form of transport by ambulance car or taxi service,
   d) Delivery of medicaments prescribed to the insured person by his/her attending physician in connection with an assistance event from a pharmacy that is the closest to the domicile of the insured person (the assistance company pays only the costs for delivery of medicaments, price of medicaments, regulatory and other charges are paid by the insured person from his/her own pocket).
   e) Transportation from the hospital after hospitalisation, which is understood as transport from a medical institute (hospital) in case of the insured person's hospitalisation, and this in dependence on the insured person's health status either in the form of transportation by ambulance car or taxi service,
   f) Rehabilitation costs for purchase of necessary rehabilitation aids, which were recommended by the attending physician or by the staff of the rehabilitation centre in connection with an insured event of the insured person (assistance service pays the costs for transportation to rehabilitation treatment and costs for rehabilitation aids up to the limit mentioned in the Supplement to these SPC. Costs for the rehabilitation itself (rehabilitation exercises prescribed by the doctor) are paid by the insured person from his/her own pocket.
   g) Delivery of food to the address of the insured person's domicile in the form of delivery of one warm or frozen main dish (in dependence on local availability) per day, (assistance service pays only the delivery costs, costs for food purchase are paid by the insured person from his/her own pocket on the basis of submitted bill),
   h) Common household cleaning in the form of provision of the following work in the flat of the insured person: wiping out and hoovering the floors, wiping the dust, cleaning the bathroom and toilet, washing the laundry and its ironing (including drying and subsequent putting it to its place), dish washing (including drying and subsequent putting it to its place), watering of plants, (costs for used detergents are borne by the insured person, the cleaning is performed with help of the insured person's technical devices),
   i) Nursing and babysitting of children in case that due to the assistance event the insured person is not able to organise this care himself/herself in the form of a caring person who would check the activity of entrusted persons in the flat of the insured person for the agreed period. At the same time, he/she would help to the entrusted persons with food preparation and its consuming, personal hygiene including bathing,
   j) Securing purchase of basic foodstuffs and hygienic needs on the basis of a written list, their delivery to the domicile of the insured person and subsequently putting them to the appointed place (assistance service pays only the delivery costs, the costs for purchase of foodstuffs and hygienic needs are paid by the insured person himself/herself from his/her own pocket on the basis of submitted bills),
   k) Visit of a doctor at the client's home in case that the insured person is so limited in his/her mobility due to the insured event that his/her transport to a health care centre would be connected with big difficulties (assistance service will organise and pay the visit of a doctor with attestation in general medicine at the domicile of the insured person for the purpose of his/her treatment). This service does not replace emergency medical service and the assistance service can deny it if it is of the opinion that the health status of the insured person requires an intervention of emergency medical service or urgent hospitalisation of the insured person if need be.
   l) Child clown in case that the insured person is a child up to the age of 12 years that is hospitalised due to the insured event (assistance service will organise and pay the visit of a child clown directly in the hospital) or at the place of the insured person's domicile after the release to domestic care (assistance service will organise and pay the visit of a child clown at the place of the insured person´s domicile)
   m) Telephone line (telephone information about children centres, events or children corners (opening hours, capacity, prices)
   n) Organisation and calling a taxi with a child car seat (assistance service pays only the costs for organisation and calling the taxi with a child car seat, costs for transport are paid by the insured person from his/her own pocket).
3. If the insured person is neither able to report the insured event to the insurance company himself/herself with regard to the severity of his/her health status nor ask for the benefit or assistance benefit, also a person close to the insured one or sharing a common household with him/her or also another person that has a legal interest in the benefit is entitled to report the insured event.
4. **Rise of an insured event (i.e. assistance event) is reported by the insured person or in case of need by a person authorised to report the assistance event without an unnecessary delay via the assistance service telephone centre**, which is in operation 24 hours a day, 365 days a year, where settlement of an assistance event is secured by employees of the assistance company (information about the telephone number is given to the insured person at insurance contract conclusion along with these SPC CAS4). In case that the assistance event is reported and the claim to assistance benefit is proven, the assistance company is obliged to provide assistance benefit latest

within 1 working day from the day when the claim to assistance benefit was proven. Written form of the assistance event's notification/reporting is not required.

5. **The claim to assistance benefit is proven by communication or submission of the following information/documents at reporting of the insured event via the assistance service telephone centre of assistance company:**
   a) **Name and surname of insured person;**
   b) **Insurance contract number;**
   c) **Place where the insured person finds himself/herself;**
   d) **Contact telephone number of insured person;**
   e) **Short description of the event or occurred situation;**
   f) **Other information and documents requested by employees of the assistance company and connected with the assistance event.**
6. **In case of assistance services with an assistance benefit limit, it is necessary to prove the claim to assistance benefit also by a medical report concerning the insured person's health status. If this medical report is not submitted to the assistance company or if it results from it that the insured person's health status was not so serious that it would make it impossible to perform himself/herself the activities that are/should be subject of assistance benefit, the assistance company is entitled to require the entire costs for provided assistance services from the insured person.**
7. If a mutual agreement is made between the assistance company and the insured person (or the person authorised to report the assistance event), the assistance company will enable to the insured person to organise the assistance service himself/herself from locally available sources and subsequently he/she will send the bills for provided assistance services along with other documents required by the assistance company to the address of the assistance company for reimbursement. Such arisen costs will be reimbursed up to the limit for assistance benefit in the sense of the Supplement to these SPC CAS4 at the most. This course of actions will be used in cases when it is more convenient for the insured person in terms of time or money than in case if the assistance services were provided by the assistance company.
8. The rider according to these SPC CAS4 and the relevant commitment of the assistance company to provide a benefit to the insured person in the form of assistance services in case of an assistant event, do not replace and even cannot replace the mission of organisations and bodies established by state or municipal authorities on the basis of the law for the purpose to secure emergency medical, fire, rescue or exploration tasks and neither financial nor any other form of compensation is provided from this rider for prospective interventions of these bodies.
9. **In case that an assistance benefit has been provided to the insured person but the assistance company has not been submitted the documents necessary to prove his/her claim to assistance benefit or if false information is provided in relation to the assistance event by the insured person (or by a person authorised to report the assistance event as the case may be), the assistance company is entitled to require compensation of the costs arisen in connection with it from the insured person.** The assistance company is also entitled to require compensation of costs for assistance services from the insured person supposing that assistance benefit has been provided in cases when the right to assistance benefit does not arise at all according to Article 5 of these SPC CAS4.
10. **The rider does not lapse by an insured event.**

Article 3 - When I should pay premium and in what amount?

1. Premium is set as regular with insurance periods agreed in the insurance contract for regular premium of the main coverage.
2. The amount of regular premium is set in the tariff of charges by a fixed amount for the whole period of the rider' duration (regardless of the insured person's age, the insurance period and any other value).

Article 4 - What period do I arrange the rider for?

1. The rider is arranged for the insurance period mentioned in the insurance contract.

Article 5 - Which cases does the rider not relate to (which exclusions are arranged)?

1. **The right to assistance benefit does not arise if the assistance event occurred in direct or indirect connection with:**
   a) **Strike, war conflict, invasion, attack (whether a war has been declared or not) by civil war, rebellion, uprising, violent or military usurpation of power, civil unrests, radioactive disaster, performance of service in armed force during a foreign mission or in another similar case;**
   b) **Alcohol consumption or taking addictive substances or misuse of medicaments by the insured person;**
   c) **Purposeful acts, criminal acts, suicide or bet;**
   d) **Disease or accidents, which occurred before the insurance start, with exception of cases when a health questionnaire was completed at conclusion of the insurance contract, this questionnaire was filled in truthfully and completely and the insurance company accepted the insured person for insurance despite of the existence of the mentioned disease;**
2. **Except of this, the right to assistance benefit does not arise if:**
   a) **It is an event, which cannot be considered as an assistance event in the sense of this term's definition in Art. 9 of these SPC CAS4;**
   b) **The insured person used the services of other legal entities without a preliminary approval of the assistance company or the services were above the frame of the financial limits mentioned in Supplement to these SPC CAS4 (such arisen costs are not paid by the assistance company).**
3. **The assistance company is entitled to adequately decrease assistance benefit, if there was an increase in the costs connected with settlement of the assistance event due to the fault of the insured person.**

Article 6 - In which situations does the rider lapse?

1. If the main coverage lapses, also this rider lapses by the day of its extinction.
2. If the insured person dies during this rider's duration, this rider lapses by the day of his/her death without compensation.
3. The rider automatically lapses in the calendar year, in which the insured person achieves the maximum age for this rider that is mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) and this as of the anniversary day of the main coverage.
4. Other ways of this rider's lapse are set by relevant provisions of GTC.

Article 7 - What other rules do this rider concern?

1. **The policyholder or the insured person is obliged to notify the insurance company of all changes in facts that were mentioned in the insurance contract (or in the proposal for change in the insurance contract if the rider is arranged to the insurance contract additionally) or that the insurance company asked about, which occur during the rider's duration, and this without unnecessary delays, however, latest within a month from the day when the change occurred. The policyholder or the insured person is especially obliged to notify the insurance company of each change in personal/contact data and further on of change in other data that have an influence on existence of insurance interest.**
2. If a period is set for a certain act in these SPC CAS4 and/or or in the relevant legal regulations and start of the period falls on a day, which is not a working one, the period starts to run only on the nearest following working day. The insurance company reserves the right to adequately prolong the arranged periods if there is an unexpected or by circumstances forced technical interruption in the functionality of the insurance company's internal systems.
3. **The insurance company has the right to perform an adequate change in these SPC CAS4 and/or in the tariff of charges in case of the rise of a reasonable need (especially in connection with the development of legal environment, at change of the relevant supervisory body's approach, in the interest of quality improvement of provided services, in connection with technical development or due to a material change in market conditions). In such a case the insurance company will deliver a written proposal of the new wording of SPC CAS4 to the policyholder to the last known contact address; if it is a change in the tariff of charges, it will publish its new wording at the websites of the insurance company.** The effective day of the change must be set in such a way that there is at least a period of 45 calendar days between delivery of the new wording of SPC CAS4 to the policyholder and/or publishing of the new wording of the tariff of charges and the effective day of this change. The policyholder has the right to deny the change in these SPC CAS4 and/or in the tariff of charges if it concerns this rider and at the same time to cancel this rider in such a case. The notice

period represents 20 calendar days from the day of the written notice delivery. **If the policyholder does not deliver a notification to the seat of the insurance company at least 30 calendar days before the effective date of the change that he/she denies the change and cancels the rider at the same time, he/she confirms his/her approval with the change in SPC CAS4 and/or in the tariff of charges by this in the wording, in which it was proposed by the insurance company.**

Article 8 - When are these special insurance conditions effective from?

These special insurance conditions become effective on May 1, 2017.

Article 9 - Vocabulary of terms – which terms are important for me

Terms, which are not defined in this Article, have the meaning that is assigned to them in GTC. The following terms are defined for these special insurance conditions:

Assistance benefit
Benefit in the form of assistance services according to Art. 2 paragraph 3 of these SPC, which the assistance company is obliged to provide from this rider to the insured person in case of an assistance event. For the purposes of these SPC CAS4 assistance benefit includes especially provision of assistance service and payment to external suppliers of these services by the assistance company.

Assistance services
Services according to Art. 2 paragraph 3 of these SPC, which are subject to assistance benefit and that the assistance company is obliged to organise for the insured person or perhaps even organise and pay, and this personally or through an external supplier of these services.

Assistance company
Legal entity, which provides assistance benefit to the insured person in the name and on behalf of the insurance company. The assistance company represents the insurance company at claiming, investigation and settlement of insured events. The assistance company or another representative entrusted by the insurance company has the right to act in the name of the insurance company at all assistance events defined by these SPC CAS4. Address of the assistance company: AXA ASSISTANCE CZ, s.r.o. Hvězdova 1689/2a, 140 62, Praha 4, Czech Republic.

Assistance event
Accident or disease that occur at the time of this rider's duration, and which require assistance benefit in the form of assistance services on the territory of the Czech Republic, which the insured person is not able to manage himself/herself due to the insured event.

Waiting period
Period, during which the obligation to provide benefit payment from events that would otherwise represent claims, does not arise to the insurance company/assistance company (period, during which right to assistance benefit does not arise to the insured person).

Supplier of services
Individual or legal entity performing for the insured person works, services or other activities belonging to assistance services organised by the insurance company through the assistance company.

Organisation of assistance serv.
Form of assistance benefit when the assistance company performs operations enabling provision of assistance service to the insured person in the scope mentioned in the insurance contract, insurance conditions or in contractual arrangements and at the same time, it pays the costs for provision of this service to suppliers of these services, which are usual in the given location and at the given time, up to the level of the limit for assistance benefit. A contingent part of the costs connected with provision of the service by a service supplier exceeding the limit for assistance benefit is borne by the insured person.

Tariff of charges
The insurance company's tariff of charges containing premium rates, maximum and minimum limits of sums assured and premium amounts, coefficients of maximum sum assured in relation to premium amount and age of the insured person and further on also information about risk groups and their influence on the level of premium for individual kinds of main coverage and riders; the topical wording of the tariff of charges is available at the websites of the insurance company or in the seat of the insurance company.

SUPPLEMENT TO SPECIAL INSURANCE CONDITIONS OF THE RIDER CAS4

Overview of assistance benefits	
Total annual limit for assistance benefits	20 000 CZK
Total annual limit for assistance benefit per assistance event	20 000 CZK
Medical assistance	
Information from the area of prevention by telephone	Available 24 hours/ 7 days in week
General health information	
Proposal for usual course of actions when solving a health problem	
Consultation of the course of treatment by telephone	
Health information telephone line	
Pharmaceutical information telephone line	
Doctor on telephone	
Transport to/from examination or treatment at a doctor	20 000 CZK
Delivery of medicaments	20 000 CZK
Transport from hospital after hospitalisation	20 000 CZK
Rehabilitation costs	3 000 CZK (transportation) 3 000 CZK (rehabilitation aids)
Home assistance	
Home assistance information telephone line	unlimited
Food delivery	20 000 CZK
Household cleaning	20 000 CZK
Nursing and babysitting of children	20 000 CZK
Organisation of purchase	20 000 CZK
Doctor's visit at the client's home	1 x per year (limit 5 000 CZK)
Child clown	3 x per year (limit 20 000 CZK)
Lifestyle information telephone line	
Information about events in children centres – opening hours, children corners, programme	Available 24 hours/ 7 days in week
Organisation, calling a TAXI with a child car seat	

IDENTIFICATION COMPLETION

1. **Identification completion**

This point is connected with the identically marked part of the insurance contract and regulates some terms used therein including possible options of answers to questions of the insurance company within identification completion of the policyholder according to requirements of Act No. 253/2008 Coll., on Certain Measures Against Money Laundering and Financing of Terrorism.

1.1. Questions of insurance company mentioned in relevant part of insurance contract (Identification completion) under letter A

Work position and subject of activity/business:

- Named profession is understood as: real estate agent and further on lawyer/accountant/tax advisor performing activity for any entity with a subject of business mentioned under the following bullet;
- Named business of natural or legal persons is understood as: lawyer/legal services; tax consultancy; notary/notarial services; accountant/accounting services; exchange offices; gambling clubs; casinos; betting shops; real estate agencies; wholesale/retail trade with alcohol, tobacco, coffee, precious stones or metals; antique shops; bazaars; pawnshops; car showrooms/second hand car sellers/trading with spare parts for cars; petrol station networks; night clubs; companies providing accommodation/catering services; companies doing business in building industry;
- Named public service is understood as: politician (member of a parliamentary party management on national level), commissioner, chief of military estate, mayor, chief magistrate, representative responsible for asset management or municipal development.

For the purpose of this Act, a politically exposed person shall mean:

a) a natural person serving or served in an important public service position with nation-wide or regional-wide competence such as especially a head of state, a head of government, a head of a central state authority and his delegate (a deputy, a state secretary), a member of the parliament, a member of a political party governing body, a head of a territorial self-government, a judge of a supreme court,a constitutional or another high-level judical body, decisions of which are not subject to further appeal, except in exceptional circumstances, a member of a bank council in a central bank, a high-ranking military officer, a member or a delegate of a member if a member is a legal entity, of a statutory body of a commercial corporation controlled by the state, an ambassador or a head of a diplomatic mission, or a natural person having or had similar responsibilities in another state, in a European Union body or in an international organization,

b) a natural person, who

1. Is a close person to the person mentioned under letter a),
2. Is a business partner or a beneficial owner of the same legal person, eventually trust fund or any other business entity without a legal personality, as a person mentioned under letter a), or it is known to obliged entity about this person that the person is in any other close business relationship with the person mentioned under letter a), or
3. Is a beneficial owner of a legal person, eventually trust fund or any other business entity without a legal personality, which are known by an obliged entity that were established in a benefit of a person mentioned under letter a).

For the purposes of the insurance contract the named country is understood as one of the following:					
Afghanistan	Djibouti	Cayman Islands	Maldives	Ivory Coast	Tanzania
Albania	Egypt	Cambodia	Mali	Equatorial Guinea	Thailand
Algeria	Ecuador	Cameroon	Morocco	Russia	Togo
Angola	Eritrea	Cape Verde Islands	Marshall Islands	Samoa	Tonga
Antarctica	Etiopia	Kazakhstan	Mauretania	Saudi Arabia	Trinidad and Tobago
Antigua & Barbuda	Philippines	Kenya	Micronesia	Senegal	Tunisia
Azerbaijan	Gabon	Comoro Islands	Moldavia	North Korea	Turkey
Bahamas	Gambia	Democratic Republic of the Congo	Mozambique	North Cyprus	Turkmenistan
Bangladesh	Ghana	Costa Rica	Myanmar (Burma)	Seychelles	Turks and Caicos
Belize	Guatemala	Crimea	Nambia	Sierra Leone	Uganda
Belarus	Guinea	Cuba	Nepal	Somalia	Ukraine
Benin	Guinea-Bissau	Kuwait	Niger	United Arab Emirates	Uzbekistan
Bolivia	Guyana	Kyrgyzstan	Nigeria	Sri Lanka	Vanuatu
Bosnia and Herzegovina	Haiti	Laos	Nicaragua	Central African Republic	Venezuela
Brasil	Honduras	Lesotho	Pakistan	Sudan	Vietnam
Brunei	Indonesia	Lebanon	Palau	Suriname	East Timor
Burkina Faso	Iraq	Liberia	Palestine	Saint Thomas and Prince Islands	Zambia
Burundi	Iran	Libya	Panama	Swaziland	Western Sahara
Chad	Yemen	Macau	Papua New Guinea	Syria	Zimbabwe
Dominican Republic	South Sudan	Madagascar	Paraguay	Tajikistan	

1.2 Tax identification

Tax residency is understood as the obligation to declare taxes in the country where the client has his/her tax obligation. The data especially such as tax residence country and tax identification number are collected for purposes of automatic international information exchange about financial accounts. If the client meets conditions for reporting of information according to the mentioned regulations, his/her data and data about the relevant insurance contracts are reported to a specialised Tax Authority by the financial institution.

1.3 Limitation of distribution

This product is not registered according to relevant legal regulations of the United States of America (hereinafter only the "U.S.A.") regulating activities regarding trading with securities and due to this reason it is not suitable for persons falling under the definition of a U.S. Person, i.e. especially for U.S. citizens and residents, green card holders and persons represented by agents and investment consultants having a seat in the U.S.A. themselves or who are U.S. Persons.