Terms and Conditions for Travel Insurance Package

Introductory provisions

The Terms and Conditions for Travel Insurance Package form an integral part of the Contract concerning voluntary health insurance of persons during travel and stay abroad, personal accident insurance of passengers, private liability insurance, luggage insurance and travel cancellation insurance taken out by the Policyholder at Allianz Zagreb d.d.

In these Terms and Conditions, the following terms shall have the following meaning:

1) **Insurer -** Allianz Zagreb d.d., the insurance company with whom the Policyholder has entered into an insurance contract;
2) **Policyholder –** the person who has entered into an insurance contract with the Insurer and may be any natural person or legal entity;
3) **Insured –** the person to whom the insurance relates and may be a natural person only;
4) **Beneficiary -** the person to whom the sum insured or indemnity is paid. In the case of death of the Insured, beneficiaries of the insurance shall be legal heirs of the Insured;
5) **Third party -** the person who is not the subject of the insurance contract, i.e. the person whose liability is not covered by the insurance;
6) **Sum insured –** the maximum amount of the Insurer's liability per single loss event;
7) **Premium –** the amount payable under the insurance contract;
8) **Policy –** the document representing the insurance contract;
9) **Insurance contract –** comprises the policy and these Terms and Conditions;
10) **Luggage –** all items for personal use during a trip, including travel souvenirs.

I. General provisions

Conclusion of insurance contract

Article 1

1. An insurance contract is concluded on the basis of a written or oral proposal, exclusively prior to commencement of a trip.

2. Travel cancellation insurance may be taken out only through a travel agency and only at the time of conclusion of a travel agreement. Where travel cancellation insurance is not concluded at the time of conclusion of the travel contract, the Insurer shall not be liable for payment of indemnity.

3. An insurance contract is considered concluded when the Policyholder and Insurer sign the insurance policy.

Insurance policy

Article 2

1. An insurance policy must contain the following information:
   1) parties to the contract
   2) insured person(s)
   3) risk covered by the insurance
   4) insurance period, including commencement and expiration of insurance coverage
   5) sum insured
   6) premium
   7) date of issue of the policy
   8) signatures of the parties to the contract

2. In the case of conflict between a certain provision of these Terms and Conditions and a certain provision of the policy, the provisions of the policy shall prevail, whereas in the case of a conflict between a certain printed provision of the policy and a certain handwritten provision of the policy, handwritten provisions shall prevail.

Commencement and duration of insurance contract

Article 3

1. Voluntary travel health insurance

Voluntary health insurance of persons during travel and stay abroad

The Insurer's liability commences at 00.00 hrs on the day which is specified in the policy as the insurance commencement date, but not before the time the Insured crosses the state border when leaving the Republic of Croatia, provided that the insurance premium has been paid in full by that time, and expires at 24.00 hrs on the day which is specified in the policy as the insurance expiration date or earlier if the Insured crosses the state border on the way back to the Republic of Croatia before that time. If a loss occurs during the insurance period, the Insurer's liability shall also exist after expiration of the insurance period.

Voluntary health insurance of foreign visitors during their stay in the Republic of Croatia

The Insurer's liability commences at 00.00 hrs on the day which is specified in the policy as the insurance commencement date, but not before the time the Insured crosses the state border when entering the Republic of Croatia, provided that the insurance premium has been paid in full by that time, and expires at 24.00 hrs on the day which is specified in the policy as the insurance expiration date or earlier if the Insured crosses the state border when leaving the Republic of Croatia before that time.

If a loss occurs during the insurance period, the Insurer's liability shall also exist after expiration of the insurance period.

2. Insurance of passengers against personal accident, private liability insurance and luggage insurance

The insurance commences on the date specified in the policy as the insurance commencement date, but not before the trip actually commences, provided that the insurance premium has been paid in full by that time. The insurance expires on the date specified in the policy as the insurance expiration date, but not after the end of the trip.

3. Travel cancellation insurance

The Insurer's liability under the travel cancellation insurance commences at 24.00 hrs on the date which is specified in the policy as the date of conclusion of the insurance contract, and expires at 24.00 hrs on the date on which **50%** of the foreseen duration of the Insured's trip expires, provided that the insurance premium has been paid in full by that time.

4. Duration of insurance period may be from a minimum of 1 day to a maximum of 365 days for all individual, family and group insurances (A, B or C plan).

If an annual individual insurance is taken out (D plan), the insurance period shall be exclusively one year subject to a maximum duration of a single trip of 28 days.

Insured event

Article 4

1. A potential event on account of which the insurance is taken out (insured event) must be a future and uncertain event that is independent of the Policyholder's or the Insured's sole will.

2. The insurance contract shall be null and void if, at the time it is concluded, the insured event has already occurred or is occurring or is certain that it will occur or a possibility that it will occur has already ceased at that time.

Payment of indemnity under the insurance

Article 5

1. When the insured event occurs, the Insurer shall pay indemnity within the agreed period which shall not be longer than 14 (fourteen) days, such period running from the day when the Insurer receives a notice that the insured event has occurred.
2. If certain time is necessary for ascertainment of existence of the Insurer's liability or determination of its amount, the Insurer is obliged to pay indemnity defined under the insurance contract within 30 (thirty) days of the date of receipt of the respective claim or to inform the Insured within the same period that his/her claim is unfounded.
3. If the amount of the Insurer's liability is not determined within the period referred to in paragraphs 1 and 2 of this Article, the Insurer is obliged to pay, without delay, the undisputable portion of his liability as advance payment.
4. If the sum insured is contracted in euro amount, the Insurer shall pay the indemnity in HRK equivalent of the euro amount according to the middle exchange rate of the Croatian National Bank on the date of settlement of the claim.

Insurance beneficiaries

Article 6

1. Voluntary travel health insurance

Within the meaning of these Terms and Conditions, the insurance beneficiary shall implicitly include the Insured, Policyholder or any other third party who proves that he/she has borne the costs that are indemnifiable under this insurance.

2. Personal accident insurance

Beneficiaries in the case of death of the Insured shall be his/her legal heirs, whereas in the case of permanent disability, beneficiary shall be the Insured him/herself.

Subrogation

Article 7

1. Upon payment of indemnity under the insurance, the rights to any remedies which the Insured may have against the person who is on any basis liable for the loss shall be assigned, by law, to the Insurer up to the level of paid indemnity.
2. If such exercise of the Insurer's subrogation rights is prevented, either completely or partially, through the Insured's fault, the Insurer shall to a certain extent be discharged from his liability to the Insured.
3. Assignment of rights from the Insured to the Insurer shall not be to the detriment of the Insured, and if the indemnity paid by the Insurer to the Insured is for any reason lower than is the loss sustained by the latter, the Insured has the right to be paid the balance of the indemnity out of the funds of the person liable for the loss prior to payment of the Insurer's claims on the basis of the rights assigned to him.
4. By way of derogation from the regulations on assignment of the Insured's rights to the Insurer, these rights shall not be assigned to the Insurer if a loss is caused by the person who is an immediate blood relative of the Insured, a person for whose acts the Insured is responsible, a person who lives with the Insured in the same household or a person who is the Insured's employee, except where these persons cause a loss deliberately.
5. However, if any person referred to in the preceding paragraph is insured with another insurer, the Insurer may request from that person's insurer to repay the amount he has paid to the Insured.
6. The provisions of this Article shall not apply to insurance of passengers against personal accident.

Settlement of disputes

Article 8

1. The parties agree that any dispute arising out of this contract shall be settled out of court.

2. The Policyholder, Insured and Beneficiary agree that they shall inform the Insurer without delay of any disputable matters, complaints and misunderstandings arising from the relationship with the Insurer.
3. The parties shall submit the information referred to in paragraph 2 of this Article in writing and it shall be written in such manner as to be able to discern clearly the contents of information, signature of the sender of the information and the time of sending of the information.
4. The Insurer shall forward the received complaint referred to in paragraph 2 above to the second-instance committee. The Insurer's second-instance committee comprises 2 (two) members of whom at least one has a B.A. degree in law. The second-instance committee shall submit its reply in writing without delay, but in any case within eight days of the day of receipt of the complaint from the other party.
5. All disputes arising from or relating to this contract, including disputes relating to the issues of its proper conclusion, breach or termination, as well as to legal effects ensuing therefrom, shall be referred to mediation before a mediation organisation active in the Republic of Croatia (for example, but not limited to, a member organisation of the Croatian Chamber of Economy or the Croatian Association of Employers). If such disputes are not settled through mediation within 60 (sixty) days from the date of submission of a proposal for initiating mediation procedure or within different period agreed by the parties, the parties shall not have any obligation in relation to this provision.
6. In the case of litigation, the court of competent jurisdiction shall be the court in Zagreb.

Limitation period

Article 9

1. Claims under the insurance contract concluded in accordance with the provisions of these Terms and Conditions shall be subject to the limitation period under the provisions of the Civil Obligations Act.

Final provisions

Article 10

1. A contract covering voluntary travel health insurance, insurance of passengers against personal accident, insurance of private liability, insurance of luggage and insurance of travel cancellation shall also be subject to other mandatory provisions of the Civil Obligations Act, and to dispositional provisions where the issues to which they relate are not regulated otherwise hereunder.

II. Special provisions

Voluntary travel health insurance

Article 11

1. An eligible Insured during travel and stay abroad in accordance with these Special provisions may be a person who is a citizen of the Republic of Croatia and a foreign national who, pursuant to the Croatian Act on the Movement and Residence of Aliens, has the following status in Croatia:

- extended stay
- stay based on a business visa
- permanent residence.

An eligible Insured during a stay in the Republic of Croatia may be any foreign visitor. A foreign visitor is a person resident outside Croatia who travels in the capacity of a tourist outside his/her usual environment for a period less than 12 months, for any purpose other than engaging in a lucrative activity in the visited place.

2. Voluntary health insurance of persons during travel and stay abroad

Under these Terms and Conditions, the insurance cover shall be valid worldwide, except for the Republic of Croatia, the countries excluded under the policy and those of which the insured foreigner is citizen.

Voluntary health insurance of foreign visitors during their stay in the Republic of Croatia

The insurance cover shall be valid in the Republic of Croatia.

Scope of the Insurer's liability

Article 12

1. The services provided by the Insurer in respect of which he pays expenses are as follows:

If the Insured is ill or injured, the Insurer shall:

- send a general practitioner or a specialist for consultation purposes;
- take the Insured to an infirmary or hospital for consultation purposes;
- organise visit to a general practitioner or a specialist;
- advise the Insured on how to reach the x-ray or scanning centre, medical laboratory or another medical institution;
- convey information by telephone where there are communication difficulties;
- provide assistance by telephone in communication (interpreting) with medical staff at a hospital if there are communication difficulties;
- convey any information necessary to the family of the Insured;
- and if the Insured requires hospitalisation, the Insurer shall:
- choose a medical institution which best suits the nature and course of the Insured's illness, book a room at a hospital, arrange transportation to the hospital, inform the hospital about the mode of payment of the invoice;
- at least once per day enquire about the Insured at the hospital to make sure the treatment proceeds correctly;
- and if the Insured chooses, at his own initiative, hospitalisation at an institution which is not suitable for the nature and course of his/her illness, the Insurer shall transfer the Insured to an institution which better suits the nature and course of the Insured's illness;

Voluntary health insurance during travel and stay abroad

and if the Insured's health condition requires repatriation, the Insurer shall organize repatriation of the Insured from the place of stay to his/her residence or to a hospital in Croatia chosen by the Insurer's medical staff and, where necessary, shall ensure that the Insured is accompanied by a medical team. Additional costs of transportation of a person accompanying the Insured shall be covered if the medical staff considers such escort necessary. If the Insured is not a citizen of the Republic of Croatia and wants to be repatriated to his/her homeland, the Insurer shall organise repatriation and assume financial liability up to the limit which corresponds to the cost of repatriation of the Insured to Croatia. Only the Insurer's physicians may decide whether repatriation is recommendable and decide on the method of repatriation. If, in the opinion of the physicians, the Insured's repatriation is possible and the Insured refuses it, the Insurer's services will be terminated instantly, in particular with regard to medical or hospital expenses incurred for the future return of the Insured to the Republic of Croatia;

Voluntary health insurance of foreign visitors during their stay in the Republic of Croatia

and if the Insured's health condition requires repatriation, the Insurer shall organize repatriation of the Insured from the place of stay to his/her residence or to a hospital in the domicile country chosen by the Insurer's medical staff and, where necessary, shall ensure that the Insured is accompanied by a medical team. Additional costs of transportation of a person accompanying the Insured shall be covered if the medical staff considers such escort necessary. Only the Insurer's physicians may decide whether repatriation is recommendable and decide on the method of repatriation. If, in the opinion of the physicians, the Insured's repatriation is possible and the Insured refuses it, the Insurer's services will be terminated instantly, in particular with regard to medical or hospital expenses incurred for the future return of the Insured to the domicile country;

Voluntary health insurance during travel and stay abroad

If, after the planned return to the Republic of Croatia, the Insured has to be hospitalised abroad for more than 7 days and if he/she is accompanied by an insured member of his/her family, the Insurer shall pay the costs of hotel accommodation of the person accompanying the Insured until the time of repatriation of the Insured. The Insurer shall pay an amount not exceeding EUR 50 per night for not more than 7 nights.

Voluntary health insurance of foreign visitors during their stay in the Republic of Croatia

If, after the planned return to his/her domicile country, the Insured has to be hospitalised in the Republic of Croatia for more than 7 days and if he/she is accompanied by an insured member of his/her family, the Insurer shall pay the costs of hotel accommodation of the person accompanying the Insured until the time of repatriation of the Insured. The Insurer shall pay an amount not exceeding EUR 50 per night for not more than 7 nights.

If the Insured pays the costs of treatment according to a prescription or costs of hospitalisation, the insurance shall cover:

- stationary treatment (first medical aid pending hospitalisation);
- medical visit in the place where the Insured gets ill;
- medicines and medical supplies prescribed by a physician;
- necessary medical aids and walking aids, which constitute an integral part of treatment of broken limbs and injuries, prescribed by physicians;
- X-ray, scanner and laboratory diagnostics;
- clinical treatment, including use of scientifically proven methods in a hospital at a place of the Insured's stay or the nearest suitable hospital;
- costs of transportation by formally approved emergency services for the purpose of admission of the Insured at the nearest hospital or at the nearest available physician, exceptionally by a taxi;
- costs of relocation to a specialist clinic where this is medically indicated and prescribed by a physician;
- surgeries, including any surgery-related expenses;
- costs of repatriation; **up to** the amount of the contracted sum insured, and
- dental treatment exclusively for the purpose of relieving acute toothache **up to** EUR 150;

In the case of death of the Insured:

- the Insurer shall organise and bear the costs of transportation of the body from the place where the death occurred to the deceased's home or bear the costs of funeral at the place of death **up to** the limit of EUR 5,800; this amount shall include the costs of coffin;
- if the family of the Insured organises transport of the Insured's body before the Insurer has approved it, the Insurer shall reimburse the costs **up to** the amount equalling the sum which would be charged to the Insurer by a person who would provide the service to the Insurer if the Insurer organised the transportation;
- if the Insured is not a citizen of a country from which he/she comes and his/her family wants to repatriate the body to the deceased's homeland, the Insurer shall organise transportation of the body and assume financial liability **up to** the limit of EUR 5,800.

Exclusion of the Insurer's liability

Article 13

1. The Insurer's liability shall be excluded in the following cases:
   - chronic diseases and consequences thereof if these existed or were known at the time of conclusion of the insurance contract;
   - illnesses treated in the last 6 months prior to inception of the insurance, including consequences thereof;
   - trips for therapeutic purposes;
   - treatment or care which is not a consequence of an emergency medical inter-

vention or accident;
- civil war, interstate war, riots, mass movements, terrorist acts and sabotage, attacks;
- any effect of radioactive origin;
- any loss or cost caused by epidemics, contamination or natural disasters that were known before departure;
- accidents occurred at the time of commitment of a criminal act by the Insured or as a consequence of intoxication or addiction (alcohol, drug, medicines) of the Insured;
- costs and consequences of any professional manual or physical activity, whether paid or unpaid;
- use of drugs or narcotics which are not prescribed by a physician;
- accident deliberately caused by the Insured and consequences of a suicidal act or attempted suicide;
- costs incurred as a result of mental illnesses or depression;
- pregnancy and consequences or complications thereof, in particular: deliberate termination of pregnancy, birth, miscarriage. However, in the case of acute complications during pregnancy, the Insurer shall pay under the policy the cost of the first medical intervention which is necessary in order to eliminate the risk to life of the mother and/or child on the condition that the pregnant woman has not attained 38 years of age and provided that 30th week of pregnancy has not expired;
- artificial insemination or another treatment of sterility and costs of contraception;
- sexually transmitted diseases, AIDS;
- accidents arising from engagement in the following sports at the amateur level: mechanical sports (automobiles, motorcycles, any motorized vehicle), airborne sports, alpinism;
- accidents arising from engagement, at the amateur or professional level, in the following sports (competition, exhibition and training) if additional premium has not been paid: air sports (professional engagement only), alpinism (professional engagement only), athletics, water sports, baseball, basketball, cricket, cycling, fencing, field hockey, combat sports, American football, golf, gymnastics, handball, horse races, mechanical sports (professional engagement only), dives, polo, rafting, rugby, scuba diving, rifle shooting, football, caving, squash, swimming, tennis, volleyball, water-polo, weight lifting, winter sports.

  Under these Terms and Conditions, amateur athletes are persons who do not pursue sport as their main activity. However, they are registered members of a sports organisation at which they train and for which they compete. Any compensation they may receive on the basis of their membership does not represent their regular income. Professional athletes are the persons who engage in sport as their primary activity (training, participation in competitions). The indemnity they receive constitutes their regular income.

  Recreationists are the persons who pursue sport on an occasional basis and who are not registered members of a sports organisation;
- accidents arising from participation in bets or occurring during or as a consequence of a criminal act or fight (except for the cases of self-defence);
- costs incurred as a result of thermal treatment, radiotherapy, phototherapy, helio therapy, cosmetic surgery;
- prostheses and costs of artificial limbs or equipment;
- costs of vaccination and costs of dental treatment (except for costs of emergency dental interventions);
- treatment or care provided by a physician who is a family member;
- indemnity of medical expenses that are already indemnifiable on the basis of other contract or right.

However, the Insurer always guarantees assistance to the insured person in any situation of mortal danger. A situation of mortal danger is deemed to be a situation

for which it may be established that the Insured would have died if there had been no medical intervention.

Exercising rights under the insurance

Article 14

1. In the case of occurrence of the insured event, the Insured is obliged to comply with the Insurer's instructions which form an integral part of the insurance policy.
2. If the Insured complies with the instructions referred to in paragraph 1 of this Article, then he/she does not have to pay in a foreign country the costs referred to in Article 12 of these Terms and Conditions.
3. The Insurer must be notified within 5 days of the occurrence of the event at the latest, except in unforeseen cases and cases of act of God.
4. In his interventions, the Insurer shall always comply with national and international legislation and legislative provisions.
5. The Insurer shall not be liable for: delays or unexpected developments during provision of contracted services in the case of strike, explosion, demonstrations, mass movements, traffic restrictions, sabotage, terrorism, civil or interstate war, consequences of radioactivity or in any other case of act of God, unforeseen circumstances or the Insurer's restricted operations.
6. If the Insured does not comply with the instructions referred to in paragraph 1 of this Article, he/she shall notify the Insurer of the reasons therefor. After establishment of the liability, the Insurer shall reimburse to the Insured the costs referred to in Article 12 of these Terms and Conditions, including the costs of house calls and purchase of medicines.
7. The Insurer is liable for payment of a claim only if the evidence of the insurance cover (original policy) is accompanied by the following documents:

1) original invoices which must contain the name of the treated person, type of illness, information about individual items of the administered medical treatment, as well as dates thereof; where the costs relate to purchase of medicines, the invoice shall include prescription issued by a physician which must clearly show prescribed medicines, their price and confirmation by the pharmacy (stamp) that the medicine has been paid; in the case of dental treatment, the information about the treated tooth and administered treatment must be specified in the invoice;
2) in the case of reimbursement of costs of transportation of the Insured's body or his/her funeral at the place of death, the invoices must be supported by an official certificate of death and a coroner's report showing the cause of death;
3) in the case of transportation to the place of residence, the invoices must be supported by a medical report verifying the necessity of transportation. The Insured is obliged to forward to the Insurer without delay all invoices sent to his/her home address for the purpose of payment. If he/she acts contrary to this provision, the Insurer shall reimburse only the costs relating to medical services that have been provided, whereas the costs of reminder and penalty interest shall be borne by the Insured him/herself.

8. The Insurer may request translation of invoices and accompanying medical documents in which case the costs of translation shall be borne by the Policyholder. If the costs of translation are borne by the Insurer, these will be deducted from the claim amount.

Article 15

1. In order to exercise the rights under the insurance, claims shall be submitted to the Insurer no later than one month after completion of medical treatment (at the visited place) or after transportation to the place of residence, or, in the case of death, after transportation of the body or after funeral at the place of death.
2. The Policyholder, Insured or Beneficiary of the insurance shall at the request of the Insurer submit all pieces of information necessary for establishment of the cause of occurrence of the insured event or scope of the Insurer's liability for pay-

ment of the indemnity, including evidence of actual commencement of the trip.
3. At the Insurer's request, the Insured undertakes to subject him/herself to a medical examination by a physician of the Insurer's choice.
4. The Policyholder and the Insured shall authorise the Insurer to obtain from third parties who are providers of medical and other services within the meaning of these Terms and Conditions any information necessary for establishment of the Insurer's liability.

Personal accident insurance of passengers

Eligibility for insurance

Article 16

1. The persons insured under these Terms and Conditions shall be included in the full liability of the Insurer regardless of their health condition, general working ability, except for mentally ill persons and persons completely deprived of business capacity who are in any case excluded from the insurance.

Definition of accident

Article 17

1. Within the meaning of these Terms and Conditions, accident is deemed to be every sudden event occurring independently of the Insured's will which operates upon his/her body externally and abruptly causing his/her death, permanent or partial disability.
2. For the purposes of the preceding paragraph, the following cases are considered to be accident: running over by a vehicle, crash, impact by or into an object, electric shock, lightning stroke, falling, slipping, tumbling down, wounding by weapons, sting or bite by animals, sting by insects, except where such sting causes an infectious disease.
3. The following cases are also deemed to be accident:
   - poisoning by chemical agents through ignorance of the Insured, except for occupational diseases;
   - infection of a wound caused by an accident;
   - poisoning due to inhalation of gases or poisonous vapours, except for occupational diseases;
   - burns caused by fire or electricity, hot objects, liquids or vapours, acids, alkalis etc.;
   - choking and drowning;
   - smothering or suffocation due to the Insured's trapping (under soil, sand etc.);
   - pulling of muscles, dislocation, spraining, rupture of bones due to abrupt bodily movements or sudden exertions caused by unforeseen external events insofar as, after the injuries have been sustained, this is diagnosed by appropriate specialist physician;
   - influence of light, sun rays, temperature or bad weather if the Insured has been directly exposed to these due to an accident which had occurred before such exposure or if he/she has found himself/herself in such unforeseen circumstances which could not have been prevented or if he/she has been exposed to such influences because of him/her saving a human's life;
   - effects of x-rays or radiation if arising abruptly or suddenly, except for occupational diseases.
4. According to these Terms and Conditions, the following cases are not deemed to be accident:
   1) contagious, occupational and other diseases and consequences of mental influences;
   2) abdominal hernia, umbilical hernia, hydroceles or other hernias, except for those which are built up as a result of a direct damage of peritoneum under direct influence of external mechanical force to the peritoneum insofar as a traumatic hernia is diagnosed after the injury and if it is clinically diagnosed

that the traumatic hernia is a consequence of injury of soft parts of peritoneum in that area;
3) infections and diseases developed because of various allergies, trimming or severance of blisters or other excrescences of thickened skin;
4) anaphylactic shock, except when it occurs during medical treatment due to a sustained accident;
5) hernia disci intervertebralis, all types of lumbagoes, discopathy, sacralgia, coccydynia, ischialgia, myofascitis, fibrositis, fascitis and all pathoanatomic changes in the region of loins and lower spine defined by analogous terms;
6) ablatio retinae of a previously sick or degeneratively changed eye, and, on an exceptional basis, ablatio retinae of a previously healthy eye will be considered as accident if there are signs of direct external injury of eyeball diagnosed in a medical institution;
7) consequences of delirium tremens and influence of narcotics;
8) consequences of medical, particularly surgical interventions which are undertaken for the purpose of medical treatment or prevention of illness, except where such consequences are caused by a proven mistake of medical staff (vitium artis);
9) pathological changes of bones and pathological epiphysiolyses;
10) neuromuscular and endocrine diseases.

The Insurer's liability in the case when the Insured is under 14 or over 75 years of age

Article 18

1. In the case of death of an insured under 14 years of age, the Insurer is only liable for payment of funeral expenses that are documented by relevant invoices.
2. If an Insured who has been affected by an accident is over 75 years of age, the Insurer is only liable for payment of **50%** of the amount which should be paid under the policy.

Scope of Insurer's liability

Article 19

1. When an accident occurs in accordance with these Terms and Conditions, the Insurer shall pay the sums insured under the insurance contract as follows:
1) the sum insured for death if death of the Insured has occurred due to accident or the sum insured for permanent disability if the total permanent disability (100%) of the Insured has occurred as a result of accident;
2) the percentage of the sum insured for permanent disability which corresponds to the percentage of permanent partial disability if the permanent partial disability of the Insured has occurred as a result of accident;
3) if the total percentage of disability exceeds **50%**, then the portion in excess of **50%** will be doubled.

Exclusions

Article 20

1. All Insurer's liabilities shall be completely excluded if an accident occurs as a result of:
1) earthquake;
2) - war, hostilities, war operations or warlike events;
   - civil war, revolution, riot, insurrection or civil commotions arising from such events;
   - detonation of explosives, mines, torpedoes, bombs or other pyrotechnic devices;
3) during training and participation in car, go-kart and motorcycle races;
4) during recreation in the following sports:
   - alpinism

- base jumping
- combat sports
- bungee jumping
- riding
- diving
- caving;

5) while engaging in the following occupations:
- mountaineering guides, participants in expeditions;
6) while operating air devices of any kind, waterborne crafts, motor and other vehicles without a proper statutory licence which authorises the driver to operate and drive such kind and type of air device, waterborne craft, motor or other vehicle;
(The Insured is deemed to be in possession of a prescribed licence when he/she drives under direct supervision of an officially authorised instructor for the purpose of preparation and undergoing a test for obtaining an official licence.)
7) as a result of attempted or committed suicide;
8) as a result of the Policyholder, Insured or Beneficiary having caused the accident deliberately;
9) while preparing for, attempting to commit or committing a pre-mediated criminal act and while escaping after he/she has committed such act;
10) as a result of influence of alcohol and/or narcotics on the Insured, regardless of any liability of a third party for occurrence of the accident. An accident is deemed to have occurred as a result of influence of alcohol if the level of alcohol in blood measured immediately after occurrence of the accident is higher than that permitted by law for operation of a vehicle, and in other cases higher than 0.80 g/kg.
The Insured is deemed to be under influence of alcohol if after a traffic accident he/she refuses to subject him/herself to a breath alcohol test, as well as if he/she leaves the place of accident before arrival of the police or if he/she fails to call the police or inform the nearest police station of the accident or if he/she otherwise avoids a breath alcohol test;
11) as a result of radioactive contamination if the intensity of radiation measured outside the micro-location range of the source of radiation is over the limit permitted by law;
12) as a result of active participation in fights, except in a proven case of self-defence.

2. The insurance contract shall be null and void if at the time of conclusion of the contract the insured loss event has already occurred or is occurring or it is obvious that it will occur, and the premium that has been paid shall be returned to the Policyholder in the amount reduced by the Insurer's expenses.

Notification of accident

Article 21

1. The Insured who is injured in an accident shall:
1) immediately see a doctor or call a doctor in order to be examined and receive medical assistance and promptly take any measure for the purpose of medical treatment, as well as to comply with medical advises and instructions regarding the manner and course of medical treatment;
2) notify the accident to the Insurer;
3) when notifying the accident, provide the Insurer with all necessary reports and information, in particular those about the place and time of occurrence of the accident, full description of the event, name of the doctor who examined him/her and referred him/her to a medical treatment or who is treating him/her, medical findings on the type and degree of the injury, possible consequences, as well as information on physical handicaps, defects or illnesses which the Insured may have sustained before occurrence of the accident.

2. If the accident results in death of the Insured, the insurance beneficiary shall

inform the Insurer thereof in writing, as well as to obtain all necessary medical and other documents.

3. Costs of medical examination and reports (initial and final medical report, further medical examination and a specialist's opinion), and other costs incurred for the purpose of proving the circumstances in which the accident occurred and the rights under the insurance contract shall be borne by the claimant.

4. The Insurer is authorised and has the right to request from the Insured, Policyholder, Beneficiary, medical institution or any other legal entity or natural person additional explanation and proofs, and to take actions at his own cost for the purpose of medical examination of the Insured by his physicians or medical boards in order to establish relevant circumstances in connection with the notified accident.

5. If the Insured fails to act in accordance with the provisions of paragraph 1, item 1 of this Article and this way contributes to development of permanent disability or to a higher degree of permanent disability than that which would develop if he/she had complied therewith, he/she shall receive a proportionally reduced benefit.

6. If the Policyholder, Insured or Beneficiary fails to notify an accident or fails to submit the complete medical and other documents, and institutes legal proceedings against the Insurer instead, such legal action shall be deemed to be premature. All costs of such legal proceedings (court charges, costs of expert opinion, fees and expenses of lawyers, witnesses etc.) regardless of outcome of the legal proceedings shall be borne by the plaintiff.

Determination of Beneficiary's rights

Article 22

1. If the Insured dies as a result of an accident, the Beneficiary is obliged to submit notification, the policy, evidence of paid premium, evidence showing that death has occurred as a consequence of accident, as well as proof of his/her right to receive the sum insured.

2. If the accident results in permanent disability, the Insured is obliged to submit: notification, policy, evidence of paid premium, evidence of circumstances in which the accident occurred and medical documentation (including x-ray pictures) showing the ascertained consequences for the purpose of determination of final percentage of permanent disability.

3. The final percentage of permanent disability shall be determined by the Insurer according to a specially coded Table of benefits for permanent disability as a consequence of an accident (hereinafter referred to as the "Table of benefits"), its title and code being specified in the policy. This percentage shall be determined upon completion of medical treatment and rehabilitation on the basis of the findings obtained by a control diagnostic treatment. Individual capabilities, social position or the Insured's occupation (professional capability) are not taken into consideration when determining the percentage of permanent disability.

4. In the case of multiple injuries of a limb or organ, the total permanent disability of a certain limb or organ cannot exceed the percentage determined by the Table of benefits for total loss of that limb or organ.

5. In the case of loss of or damage to more than one limb or organ as a result of one accident, the percentages of permanent disability for each limb or organ are added up so that the final disability is determined at up to 3⁄4 of the sum of individual disabilities, but cannot exceed 100% nor be lower than the percentage of the highest individual disability.

6. If there had been a permanent disability of the Insured as a consequence of a previous accident or degenerative illness prior to occurrence of the accident, the Insurer's liability shall be determined per the newly developed disability or as a difference between the total percentage of disability after the accident and the percentage of disability before occurrence of the accident.

7. Disability is a full or partial loss of (an) organ(s), permanent, full or partial loss of function of (an) organ(s) or parts of an organ after completion of a medical treatment. Final percentage of disability shall be determined in accordance with the Table of benefits after completion of a medical treatment at the time when the condition of the Insured in respect of the injuries and consequences thereof has stabilised, i.e. when the findings

of an appropriate specialist physician indicate that the condition cannot be expected to deteriorate or improve. If such state of stabilisation is not developed on expiry of the third year from the occurrence of the accident, the condition on expiry of this term will be considered as final condition and the percentage of permanent disability will be determined in accordance with that condition.

8. The Insurer shall reduce the final percentage of permanent disability by 1/3 (one third) if the Insured does not comply with or ignores the doctor's instructions in respect of necessary diagnostic procedures, therapy and taking of medicines.

9. If, after occurrence of an accident, it is not possible to determine the final percentage of permanent disability, the Insurer shall, at the request of the Insured, pay the amount which indisputably corresponds to the percentage of disability for which, on the basis of medical documentation, it can be ascertained that it will remain permanently.

10. If the Insured dies within a period less than 12 months of occurrence of the accident because of consequences of that accident, and the final percentage of disability had already been determined, the Insurer shall pay the amount determined for accidental death or the difference between the sum insured for accidental death and the amount which had previously been paid in respect of permanent disability if there is such difference.

11. If the final percentage of permanent disability had not been determined, and the Insured has died as a result of the same accident, the Insurer shall pay the sum insured for accidental death or just the difference between that sum insured any advance payment of the sum insured, but only in the case when the Insured dies within 3 (three) years of the date of occurrence of the accident.

Insurance of private liability

Subject-matter insured

Article 23

1. The insurance covers civil non-contractual liability of the Insured for any claim arising from death, bodily injury or deterioration of health and damage to or destruction of property of third parties:

1) in the capacity of a private person while engaging in his/her daily activities other than trade activities or any other profitable activity;
2) due to possession and use of bicycles without motors;
3) due to pursue of sport other than hunting on an amateur basis;
4) due to keeping domestic animals, except where animals are kept for the purpose of making money.

Extension of insurance

Article 24

1. To the same extent as that in Article 23, the insurance also applies to liability of the Insured's children under age (as well as grandchildren, adopted children and foster children).

Exclusions from the insurance

Article 25

1. This insurance does not cover persons under age, except as defined in Article 24 of these Terms and Conditions, nor foreign nationals, i.e. the persons who are not the citizens of the Republic of Croatia.

2. The insurance shall not apply to:

1) losses sustained by the Policyholder, Insured, his/her married or common-law spouse, co-insured persons or other persons who live with the Insured in the same household;
2) losses caused deliberately, except where a loss to a third party has been caused deliberately by a person employed at the Insured's household only for the time when household tasks are carried out;
3) losses arising from possession and use of:

- flying objects and waterborne crafts,
- motor vehicles and other vehicles which must be registered according to the legislation in force. This exclusion does not relate to vehicles which serve as a source of energy relating to the insured land (i.e. vehicles propelling another machine or plant);

4) losses caused by cold steel and weapons in general;
5) losses of and/or damages to objects or completed works which have been made or delivered by the Insured or any other person by the order or for the account of the Insured, if the loss or damage has been caused by the workmanship or delivery;
6) losses caused by defective products;
7) losses of and/or damages to third party's property caused during performance of professional activities by the Insured to these or with these objects (e.g. processing, repair, transportation, testing etc.);
8) losses caused as a result of acting contrary to legal regulations;
9) environmental losses arising from change of natural condition of water, soil and air due to harmful emissions;
10) losses of and/or damages to property of third parties taken in care, custody and control by the Insured;
11) pure financial losses, i.e. losses which are neither caused by bodily injury or health deterioration nor damage to or destruction of property.

3. The insurance does not cover liability of the Insured for losses of and/or damages to property due to:
1) permanent influence of temperature, gases, steam, moisture or deposits (smoke, soot, dust etc.), as well as due to
2) mouldiness, vibrations, noises etc.;
3) subsidence and landslide;
4) flooding by stagnant, running and ground waters;
5) losses occurring gradually.

4. In addition to this, the insurance shall not cover:
1) liability for losses directly related to use of nuclear energy, losses directly or indirectly related to high-energy ionizing radiation (e.g. alpha, beta and gama rays that are emitted by radioactive substances and neutrons or rays produced in particle accelerators or laser rays and other similar rays);
2) liability for losses directly or indirectly caused by asbestos, products or materials made of asbestos of any kind or that are in any way related to asbestos;
3) liability for losses resulting directly or indirectly from influence of magnetic, electromagnetic fields or nuclear radiation regardless of their source or occurrence;
4) liability of the Insured based on contractual extension of his/her liability to cases for which he/she is normally not liable by law;
5) losses for which the Insured is liable in the capacity of investor; however, losses for which the Insured is liable in the capacity of contracting authority and/or contractor who performs works on his/her own real estate are covered.

Territorial limits

Article 26

1. The insurance covers insured events occurred on the territory of Europe excluding the Republic of Croatia.

Insured event

Article 27

1. The insured event is a future, uncertain loss event which is independent of exclusive will of the Insured on the basis of which a third party could claim indemnity. The insured event shall be deemed to have occurred at the time when it began to occur.
2. Several consecutive losses, where such losses ensue from the same cause, shall

be deemed to be a single insured event.

Insurance validity period

Article 28

1. The Insurer shall be liable for payment of a claim only if the insured event in question occurs during the insurance period.
2. In the case of claims arising from health deterioration which develops gradually, a loss event shall be deemed to have occurred at the time when health deterioration was for the first time diagnosed by a doctor and documented by a doctor's report.

Sum insured

Article 29

1. Sum insured less any agreed deductible is the upper limit of the Insurer's liability per single insured event, even when several persons whose liability is covered by this insurance are responsible for the loss.
2. The Insured shall participate in each claim with HRK 1,500 (obligatory deductible).

Insured's obligations upon occurrence of the insured event

Article 30

1. The Insured is obliged to notify occurrence of the insured event to the Insurer within three days of gaining knowledge thereof, as well as of the respective claim that has been submitted.
2. The Insured is also obliged to notify the Insurer even when a claim against him/her is filed at the court, when he/she is taken in custody and when proceedings for submission of evidence are instituted.
3. In the case when an investigation has been carried out or an indictment issued or a decision on criminal proceedings rendered, the Insured is obliged to immediately notify the Insurer thereof, even in the case when he/she has already notified occurrence of the insured event. He/she is also obliged to submit the report on the insured event prepared by the competent body of authority.
4. The Insured is not authorised, without prior consent of the Insurer, to make any statements in respect of the claim, and in particular to admit it either in part or in whole, make settlement or payment of the claim unless the facts implicate that refusal to admit, settle or pay the claim would be an obvious injustice. In the case when the Insured mistakenly believes that his liability exists or that the established facts are true, this does not excuse him.
5. If a claimant lodges a claim against the Insured, the Insured is obliged to submit to the Insurer the summons or writ and all files related to the insured loss event and the claim and let the Insurer take over the conduct of the lawsuit.
6. If the Insured refuses to consent to any settlement recommended by the Insurer, then the Insurer shall not be liable for any amount in excess of the indemnity or interest or costs incurred due to such refusal.
7. If the claimant claims directly from the Insurer, the Insured is obliged to provide the Insurer with all proofs and information he/she has at his disposal and which are necessary for establishment of the liability for the damage which has been done and for assessment of the validity of the claim, scope and level of indemnity.
8. If, due to changed circumstances, the Insured gains such right resulting in reduction in or cancellation of annuity payable to the claimant, the Insured is obliged to notify the Insurer thereof. If the Insured does not comply with the duties set forth in this Article, he/she will bear any adverse consequences which may result from such non-compliance unless this would lead to such consequences even if he/she had complied with the duties.

Insurer's duties upon submission of claim by the injured party

Article 31

1. The following are the duties of the Insurer in respect of the claim submitted by the injured party:
   1) conduct together with the Insured the defence against invalid or excessive claims in accordance with Article 32;
   2) pay valid claims in accordance with Article 33%;
   3) reimburse the costs of legal proceedings in accordance with Article 34.

Legal protection

Article 32

1. The Insurer's duty to provide legal protection includes:
   1) investigation of the Insured's liability for the loss that has occurred;
   2) conduct of legal proceedings on behalf of the Insured in the case when the claimant exercises his/her right to indemnity in a lawsuit directly against the Insurer;
   3) making statements on behalf of the Insured which the Insurer deems useful in order to meet or defend against any invalid or excessive claim.

2. The Insurer may participate in the lawsuit in the capacity of a party interested in the outcome of the lawsuit.

Payment of indemnity

Article 33%

1. The Insurer shall pay indemnity under the insurance on the basis of:
   1) acknowledgement he has made or approved of,
   2) settlement he has made or approved of,
   3) court award, but up to and not exceeding the limit of liability under the insurance contract.

2. The Insurer is authorised to deposit the sum insured as indemnity in which case he is discharged from all obligations and procedures in respect of the loss occurrence..

3. The Insurer shall participate in depositing of indemnity for security purposes which the Insured would be obliged to deposit according to legal regulations or court award, but not in excess of the level of his liability for payment of indemnity.

4. In the case when the Insured is liable for payment of annuity as indemnity, and the paid-up value of the annuity exceeds the sum insured or the balance after deduction of other payments in respect of this insured event, the annuity due will only be compensated in such proportion as the sum insured or balance bears to the paid-up value of the annuity.

Paid-up value of annuity for calculation of the ratio shall be calculated on the basis of the life assurance mortality tables used in the Republic of Croatia.

5. If the Insurer objects to the proposal of the Insured to make an out-of-court settlement, he shall be liable for payment of the indemnity, interests and expenses even when these exceed the sum insured.

Reimbursement of costs of legal proceedings

Article 34

1. The Insurer shall reimburse all costs of legal proceedings if he conducts the lawsuit on his own or if he has given his approval to the Insured to conduct the lawsuit, even when the claim is invalid.

2. If the lawsuit has been conducted without knowledge and approval of the Insurer, the policy covers the costs of the lawsuit if these together with the indemnity do not exceed the sum insured, but only if these would have incurred even if the Insurer had given his approval to the conduct of the proceedings and if he has been informed thereof in time.

3. When the claimant exercises his/her right to indemnity in a lawsuit directly against the Insured, the Insurer shall, unless otherwise agreed, pay the amount of the awarded claim plus interest and expenses up to and not exceeding the level of

the agreed sum insured.
4. The Insurer shall pay the costs of the defence attorney in a lawsuit instituted against the Insured due to an event which could give rise to a claim for compensation of the loss on the basis of liability covered by the insurance only in the following exceptional case: if he has been informed of the chosen defence attorney and if he has agreed to pay the costs. The Insurer shall not compensate the costs of criminal proceedings and representation of the claimant.
When the Insurer pays out the indemnity and thereby fulfils his obligation under the insurance contract, the Insurer shall be discharged from further payments in respect of indemnity and costs per single insured event.

Direct claim of the injured party
Article 35
1. If the injured party lodges a claim or files a lawsuit for compensation of the loss against the Insurer only, the Insurer shall inform the Insured thereof and request from him/her to provide all necessary pieces of information and proceed in accordance with Article 30, paragraph 7 of these Terms and Conditions and to undertake all measures necessary for protection of his/her interests.
2. If in the above mentioned case the Insurer decides to pay out the indemnity to the claimant in whole or in part, he must inform the Insured thereof.
3. The injured party may request, directly from the Insurer, compensation of the loss for which the Insured is responsible, but only **up to** and not exceeding the amount of the Insurer's liability.

Insurance of luggage

Scope of the Insurer's liability
Article 36
1. The insurance covers loss of, damage to or destruction of luggage, both hand-carried and checked, during travel to and from, as well as stay in the place of destination.
2. The insurance covers loss of, damage to or destruction of luggage due to:
   a) criminal act of a third party (e.g. theft, robbery),
   b) accident of a conveyance (e.g. traffic accident),
   c) fire and natural disasters.
3. The insurance also covers transportation delays and loss of luggage handed over to the carrier.
4. The Insurer shall cover the costs of purchase of new luggage (strictly necessary clothes and basic toiletries) **up to** a maximum of EUR 250 in the case that personal luggage that has been handed over to the carrier for the purpose of transportation does not reach the same day as the Insured the destination outside the place of residence or stay during travel because of delay in transportation.
The insurance does not cover indemnity for purchase of new luggage on the return trip to the place of residence.

Exclusions and limitations of the Insurer's liability
Article 37
1. Jewellery, video equipment, photo equipment and laptops are insured only if hand-carried, but only **up to** one third of the sum insured. The insurance does not cover such objects in checked luggage.
Luggage in a parked motor vehicle is covered against theft only if it is placed in a locked factory-fitted roof box.
2. cash, securities, travel tickets and documents of all kinds are not insured.
3. Sports equipment is insured only during transportation to and from the destination and while it is placed in a locked storage space in a tourist accommodation facility at the place of stay, but is not insured during the time it is being used.
4. The Insurer shall not be liable for payment of a claim if the Insured causes the

insured event intentionally or negligently or if upon occurrence of the insured event, in particular in a loss notification report, he/she deliberately states untrue information.

Notification of insured event

Article 38

1. The Insured is obliged to notify immediately upon occurrence of the insured event the loss(es) and/or damage(s) sustained as a result of (a) criminal act(s) of a third party to a competent or nearest police station. A police report including a list of all lost or damaged items should be submitted to the Insurer along with a written loss notification within 30 (thirty) days of the date of occurrence of the insured event at the latest.
2. Losses of and/or damages to checked luggage must be notified without delay to the carrier or organisation providing accommodation services. A loss certificate must be submitted to the Insurer along with a written loss notification within 30 (thirty) days of the date of occurrence of the insured event.

Indemnity

Article 39

1. Present value of the insured item is a purchase value of a new item reduced by the estimated amount of depreciation because of its age or wear and tear.
2. If the insured items are totally destroyed or stolen and the Insured cannot prove their present value within the meaning of the preceding paragraph, the Insurer shall be liable for payment of a maximum of **50%** of purchase value of a new item.

Article 40

1. The Insurer shall pay, for each and every loss event, but **up to** and not exceeding the sum insured, the following indemnities:
   a) for lost luggage, the present value of the insured items within the meaning of Article 39 of these Terms and Conditions;
   b) for damaged items, necessary costs of repair, but not more than the present value of the insured items within the meaning of Article 39 of these Terms and Conditions, whereas for destroyed items, the indemnity paid shall be the present value reduced by any residual value, and
   c) for film accessories, CDs, DVDs and data storage media, value of the material.
2. In the case of loss of and/or damage to the luggage hand-carried by the Insured, the Insured's participation in the claim shall amount to EUR 50 per loss event.

Travel cancellation insurance

Sum insured

Article 41

1. The sum insured equals the price of the travel agreed and paid by the Insured at a travel agency in respect of which he/she has concluded an insurance contract with the Insurer.

Scope of the Insurer's liability

Article 42

1. The Insurer shall pay 90% of the amount charged to the Insured by the travel agency in accordance with the provisions concerning cancellation which are contained in the terms and conditions of the travel agreement.
2. The Insurer shall indemnify the costs of travel cancellation if the trip in question has been cancelled because of any of the following events affecting the Insured him/herself or any risk person:
   a) death
   b) sudden acute illness which requires an urgent medical care;
   c) accident involving a severe bodily injury;

d) pregnancy disorders;
e) intolerance of vaccination which the Insured was obliged to take according to valid legal regulations of the country of destination;
f) losses of and/or damages to property caused by fire, natural disaster or deliberate criminal act of a third party;
g) military exercise.

3. Risk persons within the meaning of these Terms and Conditions are:
- spouse or co-resident common-law spouse,
- children,
- parents,
- siblings,
- grandparents of the Insured or of the Insured's spouse or co-resident common-law spouse only in the case of occurrence of the event referred to in Article 42, paragraph 2, item (a) (death).

Notification of insured event

Article 43

1. The Insured is obliged within 3 (three) working days of occurrence of any reason for travel cancellation as specified in Article 41 of these Terms and Conditions to cancel the trip at the travel agency with which he/she has entered into the travel agreement.
2. If the Insured had to cancel the contracted or commenced trip for any of the reasons specified in Article 42 of these Terms and Conditions, he/she is obliged to inform the Insurer thereof in writing within 15 days, at the latest, from the date of occurrence of the reason for cancellation.

Article 44

1. The Insured is obliged, within 30 days, at the latest, of the date when the trip should commence according to the original plan, submit to the Insurer a claim along with the following documents:
a) original insurance policy;
b) payment slip and travel agreement whereby he/she confirms that the travel has been paid for;
c) a written certificate of the travel cancellation by the travel agency; the date of travel cancellation must be shown clearly and explicitly, and in the case of termination of a trip that has already commenced, the date and place of cancellation of the trip must be specified;
d) written statement by the travel agency showing the amount that has been charged to the Insured because of cancellation or termination of the trip;
e) if a trip is cancelled or terminated because of illness, bodily injury, pregnancy or intolerance of a vaccine, the Insured must submit to the Insurer the complete medical documentation relating to the illness, injury, pregnancy and vaccination, which is associated with the Insured's inability to travel, as well as a sick-leave report or the employer's certificate on the use of paid holiday in that period, if the Insured is employed;
f) if a trip is cancelled or terminated because of death, the Insured or Beneficiary must submit to the Insurer the death certificate or an extract from the Register of deaths;
g) if a trip is cancelled or terminated because of a loss of and/or damage to property or military exercise, the Insured must submit to the Insurer a certificate of the competent authority.

These Terms and Conditions shall be applied from 1 July 2006.

Table of benefits for permanent disability due to accident

General provisions

1. This Table of Benefits for Permanent Disability Due to Accident (hereinafter referred to as the "Table of Benefits") is an integral part of the General Terms and Conditions for Personal Accident Insurance and the Special Terms and Conditions for Personal Accident Insurance, as well as each personal accident insurance contract on the basis of which insurance against permanent disability due to accident is effected with Allianz Zagreb d.d.

2. The final percentage of disability is determined after completion of medical treatment and rehabilitation on the basis of the findings obtained by a follow-up diagnostic procedure. For disability of limbs and spinal column such follow-up diagnostic procedure shall not be conducted before expiry of 3 months upon completion of medical treatment and rehabilitation, except in the cases of amputations and items of the Table of Benefits where otherwise stipulated in the respective Special provisions.

If the Insured does not comply with or fails to observe doctor's instructions in respect of the required diagnostic procedures, therapy and taking of medicines, the Insurer will reduce the final percentage of disability provided for in the Table of Benefits by 1/3.

Disability is not determined for pseudoarthroses, contusion of osseous-muscular structures and overstrain syndrome.

3. In case of multiple injuries to a limb, spinal column or organ, the total percentage of disability of such limb, spinal column or organ is determined as follows: the severest consequence of injury is assigned the percentage provided for in the Table of Benefits, the second severest consequence of injury is assigned 1/2 of the percentage provided for in the Table of Benefits, the third severest consequence of injury is assigned 1/4 of the percentage provided for in the Table of Benefits and so on. The sum of percentages cannot exceed the percentage provided for in the Table of Benefits for total loss of that limb or organ.

4. When assessing disability under personal accident insurance, exclusively the percentage provided for in this Table of Benefits shall be applied.

5. The consequences of injuries to one organ are not added up and cannot be assessed on the basis of more than one item of the Table of Benefits, but they can be assessed on the basis of the item which provides for the highest percentage of disability for that particular consequence of injury.

6. In case of loss of or damage to more than one limb or organ due to one accident, the percentages of disability of individual limbs and/or organs are added up and the final percentage of disability is determined up to the level of 3/4 of thus obtained sum of individual disabilities; however, the final percentage of disability shall not exceed 100% nor be lower than the percentage of the highest individual disability.

7. If the Insured has a permanent disability which existed before occurrence of the accident, the Insurer's liability is determined with respect to the new disability, notwithstanding the pre-existing disability, except in the following cases:

a) if the notified accident has caused an increase in the pre-existing disability, the Insurer's liability shall be determined with respect to the difference between the total percentage of disability and the percentage of pre-existing disability;
b) if the Insured loses or sustains injuries on one of the previously injured organs or limbs, the Insurer's liability shall only be determined with respect to the percentage of increase in disability;
c) if it is proved by radiograph that the Insured suffered from a degenerative disease of osseous-articular system before the accident, the Insurer will reduce the final percentage of disability from the Table of Benefits by 1/3;

d) if it is proved that the Insured suffers from diabetes, central or peripheral nervous system disease, deafness, poor vision, vascular system disease or chronic pulmonary disease, and if these diseases give rise to increase in the disability following accident, the Insurer will reduce the final percentage of disability from the Table of Benefits by 1/2;

e) if a pre-existing chronic disease was the cause of the accident, the Insurer will reduce the final percentage of disability from the Table of Benefits by 1/2.

8. Subjective discomforts, muscular weakness, haematoma and other suffusions, pain, fear and post-traumatic scars on the skin which do not cause functional damages are not taken into account when determining the percentage of permanent disability. Individual abilities, social status or occupation (professional capability) are not taken into account when determining the percentage of disability.

I. Head

1. Focal or diffuse brain damages with consequential decortication and/or decerebration established during in-patient treatment in an appropriate surgical, neurological or neuropsychiatric institution:
- permanent vegetative condition;
- hemiplegia with aphasia and agnosia;
- Parkinsonian syndrome bilateral;
- severe post-traumatic dementia with psychoorganic syndrome;
- psychosis following brain injury 100%

2. Focal or diffuse brain damages with permanent neurological disturbances established during in-patient treatment in an appropriate neurosurgical or neurological institution:
- hemiplegia;
- hemiparesis with severe spasticity;
- extrapyramidal symptomatology (inability to coordinate movements or abrupt involuntary movements);
- pseudobulbar paralysis with compulsive crying or laughter;
- cerebellum damage with severe walking or coordination disorder up to 90%

3. Pseudobulbar syndrome 80%

4. Post-traumatic epilepsy established by objective diagnostic methods and treated in a neurological or psychiatric institution:

a) with frequent seizures despite appropriate medication, accompanied by changes of personality proved during treatment up to 60%

b) with occasional seizures despite medication 20%

5. Focal or diffuse brain damages with consequential psychoorganic syndrome established during in-patient treatment by objective diagnostic procedures, supported by psychiatrist's and psychologist's findings:

a) mild 30%

b) medium 40%

c) severe 60%

6. Condition after cerebral contusion proved during in-patient treatment by objective diagnostic procedures (CT, EEG):

a) without neurological disturbances 5%

b) with mild neurological disturbances 20%

c) with medium-degree neurological disturbances 35%

d) with severe neurological disturbances 50%

7. Cerebellum damages with adiadochokinesia and asynergy 40%

8. Condition after trepanation of skull vault and/or fracture of skull base proved by radiograph, without neurological disturbances 5%

9. Surgically treated intracerebral haematoma without neurological disturbances 5%

Special provisions

1. Disability under items 1 to 9 is not determined for craniocerebral injuries which are not diagnosed in hospital in the first 24 hours after such injuries have been sustained.

2. Any consequence of craniocerebral injuries must be confirmed by appropriate diagnostic methods during in-patient treatment.
3. Disability is not determined for consequences of concussion.
4. In case of multiple consequences of craniocerebral injuries due to one accident, the percentages of disability are not added up. Instead, the percentage of disability is determined on the basis of the item which is the most favourable for the Insured.
5. Permanent disability under items 1 to 9 is not assessed before expiry of one year from the date of injury, and for post-traumatic epilepsies not before expiry of two years from the date of injury.

10. Loss of scalp:
    a) half of the surface 15%
    b) whole scalp 30%

II. Eyes

11. Total loss of sight of both eyes 100%
12. Total loss of sight of one eye 33%%
13. Impairment of sight of one eye due to injury:
    - for each 1/10 of impairment of sight in excess of 50% impairment 3.3%%
14. In case that sight of the other eye has been completely lost (amaurosis):
    - for each 1/10 of impairment of sight of the injured eye in excess of 50% impairment 6.6%
15. Permanent double vision due to eye injury:
    a) external ophthalmoplegia 10%
    b) total ophthalmoplegia 20%
16. Loss of eye lens:
    a) unilateral aphakia 20%
    b) bilateral aphakia 30%
17. Partial damage to retina and vitreous body:
    a) visual field impaiment due to post-traumatic detachment of retina 3%
    b) opaque vitreous body due to traumatic bleeding 3%
18. Pseudophakia:
    a) unilateral 5%
    b) bilateral 10%
19. Permanent dilatation of pupil after a direct eye trauma 3
20. Incomplete internal ophthalmoplegia up to 10%
21. Injury to lacrimal apparatus and eye lids:
    a) epiphora 3%
    b) entropium, ectropium 3%
    c) ptosis of eye lid 3%
22. Concentric narrowing of visual field of the remaining eye (with total loss of sight of the other eye):
    a) 80 to 60 degrees up to 10%
    b) up to 40 degrees up to 30%
    c) up to 20 degrees up to 50%
    d) up to 5 degrees up to 60%
23. Unilateral concentric narrowing of visual field:
    a) 40 degrees 5%
    b) 30 degrees 10%
    c) 5 degrees 30%
24. Homonymous hemianopsia 30%

Special provisions

1. After a traumatic detachment of retina disability is determined on the basis of items 12, 13, 14 or 17, but not before expiry of one month from the date of injury or surgery.

2. Eyeball injury which caused detachment of retina must be diagnosed in hospital.
3. Permanent eye damages are assessed upon completion of medical treatment, except for the injuries under items 15 and 20 which cannot be assessed before expiry of one year from the date of injury.
4. Disability under item 19 is assessed on the basis of Maschke's Tables, subject to the provision of item 13 of this Table of Benefits.
5. Disability under items 22 to 24 is not determined for consequences of concussion or injury to soft structures of the neck (so-called whiplash injury).
6. Disability under items 22 and 23 is determined after expiry of the term defined in item 3 of these Special provisions, with new VF and EVP findings.

III. Ears

25. Total loss of hearing of both ears with normal caloric response of vestibular organ **40%**
26. Total loss of hearing of both ears with absent caloric response of vestibular organ **60%**
27. Total loss of hearing of one ear with normal caloric response of vestibular organ **15%**
28. Total loss of hearing of one ear with absent caloric response of vestibular organ **20%**
29. Partial loss of hearing of both ears with normal caloric response of vestibular organ in both ears; for combined loss of hearing (Fowler-Sabine):
a) 31-60% **up to 10%**
b) 61-85% **up to 20%**
30. Partial loss of hearing of both ears with absent caloric response of vestibular organ in both ears; for combined loss of hearing (Fowler-Sabine):
a) 20-30% **up to 10%**
b) 31-60% **up to 20%**
c) 61-85% **up to 30%**
31. Severe loss of hearing of one ear with normal caloric response of vestibular organ; loss of hearing at the level of 90-95 decibels **10%**
32. Severe loss of hearing of one ear with absent caloric response of vestibular organ; loss of hearing at the level of 90-95 decibels **12.5%**
33. Auricle injury:
- total loss or total deformation **10%**

Special provisions

1. For all consequences of injuries described in Chapter III, disability is assessed upon completion of medical treatment, however, not before expiry of 6 months from the date of injury, except for the consequences under item 33% which are assessed immediately upon completion of medical treatment.
2. If it has been established that the Insured has a pre-existing hearing damage due to acoustic trauma, disability due to loss of hearing (Fowler-Sabine) caused by the accident is reduced by 1/2.
3. Disability under items 25 to 32 is not determined for consequences of concussion or injury to soft structures of the neck (so-called whiplash injury).

IV. Face

34. Facial skin damages with scar deformities and functional disorders and/or post-traumatic deformities of facial bones:
a) medium degree **5%**
b) severe degree **15%**
35. Limited bite (distance between upper and lower teeth):
a) 5 cm to 3 cm **10%**
b) up to 1.5 cm **30%**

36. Traumatic damages to jaw bones, tongue or palate with functional disorders:
    a) medium degree 10%
    b) severe degree 25%
37. Removal of lower jaw 35%
38. Paresis of facial nerve caused by fracture of temporal bone or injury to the parotid region:
    a) medium degree 5%
    b) severe degree with contracture and mimic tic 20%
    c) paralysis of facial nerve 30%

Special provisions

1. Disability is not determined for facial disfigurement without functional disorders.
2. Disability under item 38 is assessed upon completion of medical treatment, however not before expiry of two years from the date of injury, subject to EMNG monitoring.
3. Disability is not determined for loss of teeth.

V. Nose

39. Nose injury:
    a) partial loss of nose 10%
    b) total loss of nose 30%

40. Anosmia caused by a proved fracture of the upper internal part of nasal bones 3%

41. Deformity of nasal pyramid after fracture of nasal bones with displacement of fragment 3%

Special provisions

1. If more than one consequence of nose injuries due to one accident has been determined, the percentages of disability are not added up. Instead, the percentage of disability is determined on the basis of the item which is the most favourable for the Insured.
2. Disability under item 40 is determined upon completion of medical treatment, however, not before expiry of one year from the date of injury or surgery.
3. In respect of the injury under item 41, the Insured is obliged to submit to the Insurer x-ray pictures for inspection.

VI. Trachea and oesophagus

42. Trachea injuries:
    a) condition after tracheotomy following injury 5%
    b) stenosis of trachea following injury to larynx and upper part of trachea 10%
43. Stenosis of trachea which requires permanent carrying of cannula 60%

44. Narrowing of esophagus proved by radiograph:
    a) medium degree 5%
    b) severe degree 30%
45. Total narrowing of esophagus with permanent gastrostoma 80%

VII. Thorax

46. Rib injuries:
    a) fracture of two ribs or fracture of sternum proved by radiograph healed up with displacement without restrictive reduction of pulmonary ventilation 2%

b) fracture of three or more ribs healed up with displacement without restrictive reduction of pulmonary ventilation 5%

47. Condition after thoracotomy 5%

48. Restrictive impairment of pulmonary function due to fracture of ribs, open chest injuries, post-traumatic adhesions, hematothorax and pneumothorax:
- a) vital capacity reduced by 20-30% up to 10%
- b) vital capacity reduced by 31-50% up to 30%
- c) vital capacity reduced by 51% or more up to 50%

49. Fistula following empyema 10%

Special provisions
1. Capacity of lungs is determined by a repeated spirometry test and, as required, by a detailed pulmonological examination and ergometric test.
2. If, in addition to disability defined in items 46, 47 and 49, there is a pulmonary function disorder of restrictive type, disability is not assessed on the basis of the aforementioned items, but on the basis of item 48.
3. Disability under items 48 and 49 is assessed upon completion of medical treatment, however not before expiry of one year from the date of injury.
4. Disability is not determined for fracture of one rib.
5. If it has been established by spirometry that there is a combined disorder of pulmonary function (obstructive and restrictive), the percentage of disability is reduced in proportion to the impairment of function due to illness.

50. Loss of one breast:
- a) up to 50 years of age 10%
- b) over 50 years of age 5%
- c) severe breast damage up to 50 years of age 5%

51. Loss of both breasts:
- a) up to 50 years of age 30%
- b) over 50 years of age 15%
- c) severe breast damage up to 50 years of age 10%

52. Consequences of penetrating injuries to heart and large thoracal blood vessels:
- a) heart with normal ECG and ultrasonogram 20%
- b) heart with changed ECG and ultrasonogram, depending on the severity of change up to 50%
- c) damage to blood vessels 10%
- d) aortic aneurysm with implant 40%

VIII. Skin

53. Relatively deep scars on the body following burns or injuries without functional disorders which affect:
- a) 10% to 20% of body surface up to 5%
- b) over 20% of body surface 15%

54. Deep scars on the body following burns or injuries which affect:
- a) 5% to 10% of body surface up to 5%
- b) up to 20% of body surface up to 15%
- c) over 20% of body surface 30%

Special provisions
1. Disability is not determined for beauty scars.
2. Disability is not determined for relatively deep scars which affect up to 10% of the body surface and do not cause functional disorders.
3. The cases under items 53 and 54 are assessed subject to the Rule of Nines (see chart at the bottom of the Table).
4. A relatively deep scar is developed following a deep partial-thickness burn (degree II b) and/or injury with a major skin defect.

5. A deep scar is developed following a full-thickness burn (degree III) or subcutaneous burn (degree IV) and/or major skin injury.
6. Disability is not determined for consequences of epidermal burns (degree I) and superficial skin injuries (degree II a).
7. Functional disorders caused by burns or injuries under item 54 are assessed on the basis of the appropriate items of the Table of Benefits.

IX. Abdomen

55. Traumatic hernia diagnosed in hospital immediately after injury, if at the same time also an injury to the soft parts of abdominal wall has been determined in that area 5%

56. Injury to diaphragm:
- a) condition after rupture of diaphragm diagnosed in hospital immediately after injury and surgically treated 20%
- b) diaphragmatic hernia - relapse after a surgically treated traumatic diaphragmatic hernia 25%

57. Injuries to bowels or stomach with resection 10%

58. Liver injury with resection 15%

59. Loss of spleen (splenectomy):
- a) up to 20 years of age 20%
- b) over 20 years of age 10%

60. Pancreas injury due to accident with functional damage 10%

61. Preternatural anus (permanent) 50%

62. Incontinentia alvi (permanent):
- a) partial 20%
- b) total 60%

X. Urinary organs

63. Loss of one kidney with normal function of the other kidney 30%

64. Loss of one kidney with functional damage to the other kidney:
- a) functional damage 10% to 30% up to 40%
- b) functional damage up to 50% up to 55%
- c) functional damage over 50% up to 80%

65. Functional damages to one kidney:
- a) functional damage 10% to 30% up to 10%
- b) functional damage up to 50% up to 15%
- c) functional damage over 50% 20%

66. Functional damages to both kidneys:
- a) functional damage 10% to 30% up to 20%
- b) functional damage up to 50% up to 30%
- c) functional damage over 50% 60%

67. Urine discharge disorder due to injury to urethra classified in accordance with the Charriere scale:
- a) below 18 CH up to 10%
- b) below 14 CH up to 20%
- c) below 6 CH 35%

68. Injury to urinary bladder with reduced capacity:
- for each 1/3 of reduced capacity 10%

69. Total incontinence of urine:
- a) men 40%
- b) women 50%

70. Urinary fistula:
- a) urethral 20%
- b) perineal and vaginal 30%

XI. Genital organs

71. Loss of one testicle:
- a) up to 60 years of age 15%
- b) over 60 years of age 5%

72. Loss of both testicles:
- a) up to 60 years of age 50%
- b) over 60 years of age 25%

73. Loss of penis:
- a) up to 60 years of age 50%
- b) over 60 years of age 30%

74. Deformity of penis which prevents cohabitation:
- a) up to 60 years of age 50%
- b) over 60 years of age 30%

75. Loss of uterus and ovaries up to 55 years of age:
- a) loss of uterus 30%
- b) loss of one ovary 10%
- c) loss of both ovaries 30%

76. Loss of uterus and ovaries over 55 years of age:
- a) loss of uterus 10%
- b) loss of each ovary 5%

77. Damages to vulva and vagina which prevent cohabitation:
- a) up to 60 years of age 50%
- b) over 60 years of age 15%

XII. Spinal column

78. Spinal column injury with permanent total damage to spinal cord or peripheral nerves (paraplegia, triplegia, tetraplegia) with loss of control of defecation and urination 100%

79. Spinal column injury with total paralysis of lower extremities without defecation and urination disorders 80%

80. Spinal column injury with permanent partial damage to spinal cord or peripheral nerves (tetraparesis, triparesis) without loss of control of defecation and urination, proved by EMG up to 50%

81. Spinal column injury with paraparesis, proved by EMG up to 40%

Special provisions

Disability under items 78 and 79 is assessed after determination of permanent neurological damages and that under items 80 and 81 upon completion of medical treatment, however, not before expiry of two years from the date of injury.

82. Consequences of fracture of a minimum of two vertebrae with change of physiological curvature of spinal column (kyphosis, scoliosis):
- a) medium degree up to 15%
- b) severe degree 30%

83. Reduced spinal mobility following injury to corpus of cervical vertebra 3%

84. Reduced spinal mobility following injury to corpus of lumbar vertebra - severe degree 10%

85. Fracture of transverse processes of three or more consecutive vertebrae 3%

Special provisions

1. For assessment of disability under items 82, 83, 84 and 85 the Insured is obliged to submit to the Insurer x-ray pictures for inspection.
2. Disability following a spinal column injury under items 83, 84, and 85 is assessed subject to a measurement 6 months upon completion of medical treatment and rehabilitation.

3. Disability is not determined in case of retroflexion of cervical vertebrae over 6 cm.
4. Herniation of intervertebral disk, all types of lumbago, discopathy, spondylosis, spondylolisthesis, spondylolysis, sacralgia, myofascitis, coccyodynia, ischialgia, fibrositis, fascitis and all pathoanatomical changes in the sacrolumbar region, appropriately termed, as well as painful cervical vertebrae syndromes are not covered under the insurance.

XIII. Pelvis

86. Multiple fracture of pelvis with severe deformity or displacement of sacroiliac joints or symphysis 30%
87. Symphysiolysis with horizontal and/or vertical displacement:
a) 1 cm in size 10%
b) 2 cm in size 15%
c) over 2 cm in size 25%
88. Fracture of one iliac bone, healed up with displacement 5%
89. Fracture of both iliac bones, healed up with displacement 10%
90. Fracture of pubic bone or ischium, healed up with displacement 5%
91. Fracture of two bones: two pubic bones or two ischia, or pubic bone and ischium, healed up with displacement 10%
92. Fracture of sacral bone, healed up with displacement 5%

Special provisions
1. Disability is not determined for fracture of pelvic bones which have healed up without displacement and without objective functional disorders.
2. Disability is not determined for fracture of coccyx.

XIV. Arms

93. Loss of both arms or both hands 100%
94. Loss of arm at shoulder (exarticulation) 70%
95. Loss of arm in the upper arm region 65%
96. Loss of arm below elbow with preserved function of elbow 60%
97. Loss of one hand 55%
98. Loss of all fingers:
a) on both hands 90%
b) on one hand 45%
99. Loss of thumb 20%
100. Loss of index finger 12%
101. Loss of:
a) middle finger 7%
b) ring finger or little finger, for each finger 3%
102. Loss of metacarpal bone of thumb 6%
103. Loss of metacarpal bone of index finger 4%
104. Loss of metacarpal bone of middle, ring and little finger, for each bone 2%

Special provisions
1. For loss of one phalanx of thumb disability is determined at 1/2 of the percentage for loss of thumb and for loss of one phalanx of any other finger disability is determined at 1/3 of the percentage for loss of that finger.
2. Partial loss of osseous part of a phalanx is deemed to be equivalent to total loss of phalanx of that finger.
3. For loss of a fingertip disability is determined at 1/2 of the percentage for loss of phalanx of that finger.

105. Total stiffness of shoulder joint:

a) in functionally unfavourable position (abduction 20 to 40 degrees) 35%
b) in functionally favourable position (abduction up to 20 degrees) 25%

106. Fractures in the shoulder region healed up with displacement or intraarticular fractures which impair mobility of shoulder joint, proved by radiograph 3%

Special provisions

Disability under items 105 and 106 is assessed 6 months upon completion of medical treatment and rehabilitation.

107. Unsteadiness of shoulder joint with osseous defect of ball and socket up to 10%
108. Endoprosthesis of shoulder joint 30%
109. Chronic osteomyelitis of arm bones with fistula 10%
110. Paralysis of accessory nerve 15%
111. Paralysis of brachial plexus 60%
112. Partial paralysis of brachial plexus (Erb's paralysis - upper part or Klumpke's paralysis - lower part) 35%
113. Paralysis of peripheral arm nerves:
a) n. axillaris 15%
b) n. radialis 30%
c) n. medianus 35%
d) n. ulnarius 30%
114. Paralysis of two nerves of one arm 50%
115. Paralysis of three nerves of one arm 60%

Special provisions

1. Disability is not determined for dislocation of acromioclavicular or sternoclavicular joint and for pseudoarthrosis of humerus.
2. Disability is not determined for consequences of fracture of clavicle.
3. A maximum level of disability to be determined for paresis of a nerve is 2/3 of the percentage of disability stipulated for paralysis of that nerve.
4. Disability under items 110 to 115 is determined upon completion of medical treatment and rehabilitation, but not before expiry of two years from the date of injury, subject to the damages being proved by an EMG finding which is not older than 3 months.
5. Disability is not determined for damages to the roots of spinal nerves of cervical vertebrae (so-called radicular damages).

116. Total stiffness of elbow joint:
a) in functionally unfavourable position 25%
b) in functionally favourable position from 100 to 140 degrees up to 15%

117. Fractures in the elbow region healed up with displacement or intraarticular fractures which impair mobility of elbow joint, proved by radiograph 3%
118. Unsteady elbow joint - loose movement in transverse direction over 20 degrees 5%

Special provisions

Disability under items 116 to 118 is assessed 6 months upon completion of medical treatment and rehabilitation.

119. Endoprosthesis of elbow: 25%
120. Total stiffness of forearm:
a) in supination 25%
b) in mid position 15%
c) in pronation 20%
121. Total stiffness of wrist:
a) in extension 15%
b) in forearm axis 20%

c) in flexion 30%

122. Fractures in the wrist region healed up with displacement or intraarticular fractures which impair mobility of wrist, proved by radiograph 3%

123. Endoprosthesis of scaphoid bone and/or lunate bone 20%

Special provisions

1. Disability is not determined for pseudoarthrosis of forearm, radius or ulna or scaphoid or lunate bone.
2. Disability under items 120 to 122 is assessed 6 months upon completion of medical treatment and rehabilitation.
3. Disability is not determined for consequences of fracture of metacarpal bones.

124. Total stiffness of all fingers of one hand 40%

125. Total stiffness of individual fingers:

a) whole thumb 12%
b) whole index finger 9%
c) whole middle finger 5%
d) ring finger or little finger, for each finger 2%

Special provisions

1. For total stiffness of one joint of thumb, disability is determined at 1/2 of the percentage for total stiffness of thumb and for total stiffness of one joint of any other finger, disability is determined at 1/3 of the percentage for total stiffness of that finger.
2. The sum of percentages determined for stiffness of individual joints of one finger cannot exceed the percentage for total stiffness of that finger.
3. Total disability determined for injuries to fingers cannot exceed the percentage of disability provided for loss of hand.
4. Disability for the consequences of injuries to fingers is determined without application of the principle defined in item 3 of the General Provisions of the Table of Benefits.

XV. Legs

126. Loss of both upper legs 100%
127. Exarticulation of leg at hip 70%
128. Loss of upper leg at the upper third, stump unsuitable for prosthesis 60%
129. Loss of upper leg below the upper third 50%
130. Loss of both lower legs, stump suitable for prosthesis 80%
131. Loss of lower leg, bone stump shorter than 6 cm 45%
132. Loss of lower leg, bone stump longer than 6 cm 40%
133. Loss of both feet 80%
134. Loss of one foot 35%
135. Loss of foot - Chopart's amputation 35%
136. Loss of foot - Lisfranc's amputation 30%
137. Transmetatarsal amputation 25%
138. Loss of metatarsal bone I and V 5%
139. Loss of metatarsal bone II, III and IV, for each bone 3%
140. Loss of all toes of one foot 20%
141. Loss of great toe:

a) distal phalanx of great toe 5%
b) loss of whole great toe 10%

142. Total loss of toe II to V, for each toe 2.5%
143. Partial loss of toe II to V, for each toe 1%

Special provisions

Stiffness of interphalangeal joints of toe II to V in extension or reduced mobility of these joints does not represent disability.

144. Total stiffness of hip:
- a) in functionally unfavourable position 40%
- b) in functionally favourable position 30%

145. Fractures in the hip region healed up with displacement or intraarticular fractures which impair mobility of hip, proved by radiograph 3%

146. Total stiffness of both hips 70%

147. Old traumatic dislocation of hip which has not been repositioned 40%

148. Deforming post-traumatic arthrosis of hip following fracture which impairs mobility of hip, proved by radiograph - compared with the healthy hip reduction over 2/3 of range of motion of the joint up to 20%

149. Improperly healed fracture of femur with angulation by:
- a) 10 to 20 degrees up to 10%
- b) over 20 degrees 15%

150. Chronic osteomyelitis of leg bones with fistula 10%

Special provisions

1. Disability is not determined for pseudoarthrosis of femur and femoral neck.
2. Disability under items 144 to 149 is assessed 6 months upon completion of medical treatment and rehabilitation

151. Endoprosthesis of hip:
- a) partial 15%
- b) total 30%

152. Shortening of leg following fracture:
- a) 2 - 4 cm up to 10%
- b) 4.1 - 6 cm up to 15%
- c) over 6 cm 20%

153. Total stiffness of knee:
- a) in functionally unfavourable position 35%
- b) in functionally favourable position (flexion up to 10 degrees) 25%

154. Deforming arthrosis of knee following injury to ball and socket which impairs mobility, proved by radiograph - compared with the healthy knee reduction over 2/3 of range of motion up to 20%

155. Fractures in the knee region healed up with displacement or intraarticular fractures which impair mobility of knee, proved by radiograph 3%

156. Unsteadiness of knee following injury to ligamentous structures, compared with the healthy knee, which requires permanent carrying of orthopaedic apparatus 20%

Special provisions

1. Disability under items 153 to 156 is determined 6 months upon completion of medical treatment and rehabilitation.
2. Disability is not determined for damage to and/or surgical removal of meniscus.
3. Disability is not determined for unsteadiness of knee as a consequence of surgical removal of meniscus.

157. Endoprosthesis of knee
- a) partial 15%
- b) total 30%

158. Loose intraarticular body developed after knee injury, proved by radiograph 3%
159. Functional disorders following removal of patella:
a) partially removed patella 5%
b) completely removed patella 15%
160. Improperly healed fracture of lower leg proved by radiograph with valgus, varus or recurvation deformity, over 15 degrees compared with the healthy lower leg: up to 15%
161. Total stiffness of ankle joint:
a) in functionally unfavourable position 25%
b) in functionally favourable position
(plantar flexion 5 to 10 degrees) up to 20%
162. Fractures in the ankle joint region healed up with displacement or intraarticular fractures which impair mobility of joint, proved by radiograph 3%

Special provisions
1. Disability is not determined for pseudoarthrosis of patella or tibia.
2. Disability under items 160 to 162 is determined 6 months upon completion of medical treatment and rehabilitation.
3. Disability is not determined for injuries to ligamentous structures of ankle joint (distortion).

163. Endoprosthesis of ankle joint 25%
164. Traumatic dilatation of malleolus, compared with the healthy malleolus 5%
165. Deformities of foot: pes excavatus, pes planovalgus, pes varus, pes equinus - severe degree 5%
166. Deformity of calcaneus following compression fracture 5%
167. Deformity of talus following fracture with deforming arthrosis, proved by radiograph 5%
168. Deformity of metatarsus following fracture of metatarsal bones (for each metatarsal bone 1%) up to 5%

Special provisions
1. For assessment of disability under items 164 to 168, the Insured is obliged to submit to the Insurer x-ray pictures for inspection.
2. Permanent disability under items 164 to 168 is determined 6 months upon completion of medical treatment and rehabilitation.

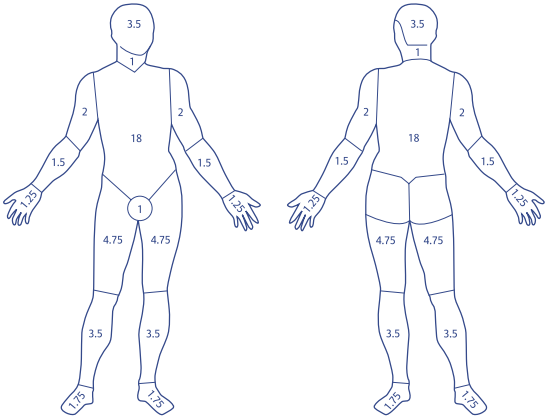
169. Total stiffness of distal joint of great toe 1.5%
170. Total stiffness of proximal joint of great toe or both joints 3%
171. Large scars on heel or sole following injury to soft parts
- over 1/2 of sole up to 10%
172. Paralysis of leg nerves:
a) n. ischiadicus 40%
b) n. femoralis 30%
c) n. tibialis 25%
d) n. peroneus 25%
e) n. glutealis 10%

Special provisions
1. Disability under item 172 is determined upon completion of medical treatment and rehabilitation, but not before expiry of two years from the date of injury, subject to the damage being proved by an EMG finding which is not older than 3 months.
2. A maximum level of disability to be determined for paresis of a leg nerve is 2/3 of the percentage stipulated for paralysis of that nerve.
3. Disability is not determined for damage to the roots of spinal nerves of the lumbar region (so-called radicular damages).

Assessment of burned area according to wallace's rule

Rule of nines

- Head and neck	9%
- One arm	9%
- Anterior trunk	2 x 9%
- Posterior trunk	2 x 9%
- One leg	2 x 9%
- Perineum and genitals	1%



This Table of Benefits shall take effect and apply as of 1st March 2003.