

Terms and Conditions of STÚDIUM Accident and Health Insurance

The present general insurance terms and conditions shall, unless otherwise agreed by the parties hereto, be applicable to the accident- and health- insurance policies offered by Generali-Providencia Biztosító Zrt. (1066 Budapest, Teréz krt. 42-44.), provided that the insurance contract (hereinafter: contract) has been concluded with reference to the present conditions.

Matters not regulated by this policy conditions shall be governed by the provisions set forth in the 'Product Information on Generali-Providencia Zrt's Stúdium Accident and Health Insurance', the Hungarian Civil Code and other relevant effective Hungarian legislation.

In case of any eventuell difference the provisions of the Health insurance contract shall prevail.

Section 1 Definition of Terms

1.1. **Illness** shall mean a bodily or mental condition which is irregular according to the current state of generally recognized development of medical science.

1.2. **Accident:** a sudden, one-time, external physical or chemical impact occurring during the period of insurance, independently of the will of the insured and resulting in a permanent health impairment of the insured, or the death of the insured.

1.3. **Health care:** any and all health care activities that can be pursued in possession of an operation permit issued by the health care authority (the Hungarian medical officer's and professional supervision), which aims at examining and treating the patient, caring for, attending him/her, decreasing pain and suffering and for the purpose of the above, the processing of the patient's examination documents in order to preserve the insured person's health, as well as for the prevention, early recognition, establishment, treatment of illnesses, averting dangers of life, improving the condition occurred due to attaches, or as a consequence of accidents and for the purpose of preventing further condition deterioration.

Health care shall furthermore include activities related to medications, bandage, medical aids, medical care in accordance with effective legislation, as well as rescue and patient transport.

1.4. **Primary health care:** health care services which can be freely received by the insured person at his/her own discretion, without the physician's order.

1.5. **Specialized health care:** health care used by the insured person upon the physician's order.

1.6. **Health care service provider:** an organization which is recognized by the medical authorities (Hungarian medical officer's and professional supervision), is entitled to provide health care services in accordance with effective legislation, and whose operation is authorized in Hungary.

For the purposes of the present conditions, **health care service provider shall not include** sanatoriums, rehabilitation institutes, thermal or hydro-mineral establishments, asylums and care centers for patients with mental disorders and other psychiatric diseases, geriatrics, chronic institutes, social homes, alcohol and drug detoxification institutes (hereinafter jointly referred to as: other health care institutions), even if these provide health care services, or departments of health care institutions which provide health care services in line with the operations of health care institutions as defined herein (for the purposes of this section, hereinafter: department), provided that the insured person has received services in line with the specialization of the other health care institution or of the department.

1.7. **Designated health care service provider:** the health care service provider contracted with the Insurance Company to render health care services and specifically named on the Health Insurance Card by the Insurance Company.

1.8. **Outpatient care** shall be provided for any person who, as a result of an accident or illness, receives primary medical or specialist care the duration of which does not exceed 24 hours, and which is not considered as inpatient care.

1.9. **Inpatient care** shall be provided for any person who, as a result of an accident or illness, is hospitalized in a health care service provider institution for several days to receive medical attention,

and the person spends every night during his/her hospitalization, between admission and release, in such institution in connection with the medical treatment. The insured shall be hospitalized for multiple days if his/her release from the health care institution is on a later day than that of his/her admission.

1.10. Emergency: a sudden change in health conditions as a consequence of which the insured person's life would be at direct risk, or could suffer severe or permanent injury to health without receiving immediate medical attention.

1.11. Pre-paid health care: health care services provided by a person or institution duly authorized to render health care services, received by the insured in medically justified cases, where the costs are settled to the service provider directly by a person or entity other than the insurance company.

1.12. Insured's statement is a written document which contains the insured's declarations with respect to the health insurance contract, and in particular information regarding the rights and obligations of the insured, the exemption from confidentiality obligations related to authorities and institutions, as well as the insured's Loss Payable Statement with respect to the payment of services, which is to be an integral part of the insured's statement.

1.13. Health insurance card: A numbered card issued by the insurance company containing the most important data related to the insurance status, which is designed to be proof of the insured status before the Health care service provider.

1.14. Limit applicable to the insurance period: the upper threshold of the Insurance Company's total benefit payment applicable to the insured's medical treatment during a given insurance period specified for each benefit type in the Stúdium Product Information which is an integral part of the contract and these policy conditions, above which the Insurance Company shall not be bound to provide services (pay benefits).

1.15. Deductible (or excess): a lower threshold of the Insurance Company's benefit payment obligation applicable to any one insured event and to any one insured as specified in the Stúdium Product Information, which is an integral part of the contract and these policy conditions. The deductible is the amount which the insured shall pay in relation with the insured's medical or health care treatment.

Section 2 General Provisions

2.1. Parties to the insurance contract (insurance company, policyholder, insured)

2.1.1. The **Insurance Company** is Generali-Providencia Biztosító Zrt. (hereinafter: insurance company) who shall, in consideration of the insurance premium payment, bear the insurance risk during the insurance period specified in the contract, and undertakes the obligation to pay the insurance benefits set forth in these general terms and conditions.

2.1.2. The **Policyholder** may be the Central European University, CEU Educational and Service Non-profit Public Interest Ltd., the Central European University, the Közép-európai Egyetem Kft (Central European University Ltd – Hungary), the Budapest Central European University Foundation, the CEU Business Innovation Ltd, and the CEU Business School Foundation (acting in representation of these entities, pursuant to their authorization: Central European University), who enters into the insurance contract and undertakes to pay the insurance premium.

2.1.3. The **Insured** may be any natural person whose health condition is covered in the insurance contract with respect to specific insured events.

2.1.4. For the purposes of this insurance contract, **the insurance may be taken out for any person who, during the term of the contract or the period of the insurance, is employed by the Policyholder or has any other form of legal relationship for performing student/work/research with the Policyholder or receives a scholarship from the Policyholder, who is resident in Hungary and is over 18 but under 65 years of age**, provided that such person is not insured under the national social insurance scheme in Hungary and who completes and signs the insured's statement and the Health Insurance Card to apply for insurance coverage under the insurance contract.

Furthermore, the insurance may be taken out for any close relative of a person employed by / or having any other type of legal relationship for performing work/research with the policyholder, who private individual under 18 or over 65 years of age and lives in the same household with the person defined

above, is resident in Hungary and who has signed the insured's statement executed in a separate document and enclosed hereto as Schedule 3, an integral part of the agreement, as well as the Health Insurance Card enclosed hereto as Schedule 5, to explicitly apply for insurance coverage under this insurance policy, or whose legal representative has done so.

Close relative: nearest relatives shall mean in the interpretation of the present contract the spouse, partner, registered partner and child (including adoptive or stepchild or foster child). Close relationship shall be testified with an extract from the registrar or the registry of partnership declarations kept by the notary public.

2.1.5. For the purposes of these policy conditions, no one engaged in the following occupations or pursuing the following activities may be insured:

stuntmen, circus artists, equilibrists, test pilots, parachute jumpers, jet plane crew in the army, bodyguards, commando staff, foreign legionnaires, peacekeepers, secret agents, armed guards, armored car personnel, contractors working in the army or persons in conscription who pursue increased danger activities (e.g. bomb experts, divers).

2.1.6. The beneficiary of all insurance benefits due in the life of the insured shall be the insured himself. If the insured dies, the beneficiary of the proceeds shall be the heir(s) of the insured.

2.2. Execution of the insurance contract and the conclusion of the insurance

2.2.1. The contract shall be concluded by execution of a written agreement by and between the Policyholder and the insurance company.

2.2.2. The insured's statement shall constitute a part of the contract.

2.2.3. The insurance shall be concluded for the particular insured when the insured's statement referred to in Section 1.12 and the Health Insurance Card referred to in Section 1.13 are signed by the Insured.

2.2.4. The insurance company shall be entitled to collect advance premium prior to the execution of the contract, or prior to the commencement of the insurance coverage applicable to the particular insured in the amount applicable to the particular insured for the given insurance period/insured months, which shall be regarded as an interest-free advance payment.

If the contract is concluded, or the insurance coverage of the particular insured is commenced, the insurance company shall include the premium advance in the insurance premium. In case the contract is not concluded, the insurance company shall refund the advance premium to the policyholder.

2.2.5. Before the insurance is concluded, the insurance company is entitled to carry out underwriting (risk assessment) and for that purpose it may require a statement of health (pre-conditions), medical tests or other written declarations from the insured. The insurance company shall be entitled to verify the data so obtained.

2.2.6. In the medical history statement, as well as in all other written declarations, all data or circumstances explicitly requested by the insurance company in the form of questions or in a statement must be true and accurate.

2.2.7. When the insurance is concluded, the insurance company issues a Health Insurance Card for the insured, which contains the most important data related to the insurance and which shall be signed by the Insured in accordance with Section 2.2.3.

2.3. Commencement of the insurance coverage (effective date of the contract)

2.3.1. The insurance coverage of a particular insured shall commence **at 0 hours on the day following the day when this insured's statement and the Health Insurance Card** are signed by the insured, or if the insured's statement and the Health Insurance Card are signed prior to the commencement of the insurance period specified on the insured's statement or the Health Insurance Card, coverage shall commence at 0 hours on the first day of the insurance period, and **shall terminate on the last day of the insured month specified on this insured's statement (hereinafter: insurance period)**, provided that the Policyholder has paid the insurance premium applicable to the particular insured in full - taking account of deferred premium payment and the frequency of premium payment - for the whole of the

insurance period applicable to the insured as specified in the insured's statement and the Health Insurance Card.

2.4. Period of insurance

2.4.1. This health insurance contract is concluded for an indeterminate period of time.

2.4.2. Within the policy year/financial year the insurance will provide coverage for determinate insurance periods and insurance months.

2.4.3. Policy year/financial year: 1 (one) year, commencing on August 1 of the given year and ending on July 31 of the subsequent calendar year. The policy year/financial year can be divided into insurance months and insurance periods.

2.4.4. Insurance month shall mean a calendar month covered by insurance premium it being understood that any one insurance month shall start on the 1st day of the calendar month and ends on the last day of the same month, on the understanding that the first day of first insurance month of the insurance shall be the commencement day of the insurance coverage, it being understood that the Insurance Company shall require that a whole monthly premium applicable to the particular insured shall be paid for the first month of the insurance, as well.

2.4.5. The insurance period shall be specified on the insured's statement and on the Health Insurance Card.

2.5. Termination of the insurance, termination of the insurance coverage

2.5.1. The insurance shall terminate:

- a) at the date specified on the insured's statement (at the end of the insurance period), or
- b) if the insurance contract between the Policyholder and the Insurance Contract terminates for whatever reason, or
- c) in the case of a premium payment default, after 30 days from the due date of the first missed premium, or
- d) at the end of the insurance period in which the insured reaches the age of 65, save for the case when the Insurance Company, subject to an individual risk assessment, undertakes to provide the coverage even after such age limit has been reached by the Insured, or
- e) if the Insured's employment, service contract, enrollment and/or research fellowship with the Policyholder terminates for any good reason, or if it is a close relative living in the same household with insured that is employed or contracted by the policyholder or has research fellowship at the policyholder and the employment or service contract or research fellowship of such close relative is terminated at the Policyholder.
- f) if the insured dies.

If the insurance premium paid by the Policyholder is not enough to cover the cost of the insurance for the full insurance period, the insurance coverage with respect to the particular insured will terminate on the 30th day from the last day of the insurance month which is covered by insurance premium.

2.6. Geographical limit of the insurance

2.6.1. The insurance coverage shall only be applicable in the territory of Hungary.

2.7. Obligation of the policyholder and the insured to disclose data and report changes

2.7.1. The policyholder and the insured shall comply with their obligation to disclose data and report changes.

2.7.2. Obligation to disclose data shall mean that when making an insurance proposal the policyholder and the insured person shall declare to the insurance company all circumstances which may be relevant for underwriting and which they are or must have been aware of. Parties shall comply with their

obligation to disclose data by answering the written questions of the insurance company provided that such statements and answers are true and accurate.

2.7.3. Obligation to report changes shall mean that during the insurance period the policyholder and the insured shall give written notification of any change in any relevant condition specified or included in the contract within 15 days following such change. Relevant condition shall include everything that the insurance contract provides for or which the insurance company has asked or which was required to be stated.

2.7.4. The insurance company shall be entitled to verify any disclosed data.

2.7.5. If the obligation to disclose data and report change is infringed, the insurance company shall be exempt from payment of the insurance benefit, save for the case when it is proven that the undisclosed or undeclared condition was known or must have been known to the insurance company at the time when the insured event occurred.

2.7.6. The occurrence of any of the above cases shall be evidenced by the party that refers to it.

2.7.7. If the insurance company becomes aware of any relevant condition after the conclusion of the contract, it may initiate the amendment of the contract within 15 days after obtaining such information, or if it does not accept the risk under the new circumstances, it may terminate the contract in writing giving 30 days notice.

2.7.8. If the policyholder does not accept the proposed amendment or does not respond within 15 days upon receipt of notification thereof, the contract shall terminate on the 30th day after the notification of the amendment was served. The policyholder shall be advised of this consequence at the same time when the notification with the proposed amendment is served. Should the insurance contract fail to exercise this right, the contract shall remain in force on the original terms.

2.7.9. If the insurance company becomes aware of an infringement of the disclosure obligation with respect to a relevant material circumstance in the insured's declaration within the duration of the contract the insurance company may carry out underwriting for the particular insured, and based on its findings, it may propose an amendment of the insurance contract with respect to the particular insured within 15 days or, if pursuant to these general terms and conditions the insurance company does not undertake the risks, the insurance company may cancel the insurance contract with respect to the particular insured giving a 30-day written notice of the discovery of the infringement.

2.7.10. If the policyholder does not accept the proposed amendment with respect to a particular insured or does not respond within 15 days upon receipt of notification thereof, the contract with respect to the particular insured shall terminate on the 30th day after the notification of the amendment was served. The policyholder shall be advised of this consequence at the same time when the notification with the proposed amendment is served. Should the insurance company fail to exercise this right, the contract shall remain in force on the original terms with respect to the particular insured.

2.8. Insurance premium

2.8.1. **The insurance premium shall be paid by the Policyholder.**

2.8.2. The policyholder shall fulfill his/her obligation to pay the insurance premium as of the day when the insurance premium is credited to the account of the insurance company.

2.8.3. The method and frequency of the premium payment shall be agreed by the Policyholder and the Insurance Company and specified in the health insurance contract.

2.8.4. Parties hereby agree that if the Policyholder fails to pay the insurance premium, the health insurance contract shall terminate on the 30th day following the due date of the insurance premium.

2.8.5. If the contract is terminated as a result of a default on premium payment, the insurance company shall be entitled to claim insurance premiums in proportion to the actual period in which coverage was provided.

Section 3 Insurance coverage

3.1. Insured event

3.1.1. The insurance covers events when, during the period of insurance applicable to the insured, the insured receives health care services in a medically justified case as a result of an accident or illness from a health care service provider named (designated) on the Health Insurance Card in accordance with the conditions of the contract. Health care services received in other institutions shall only be covered if the condition of the insured did not make it possible to be treated in the designated institution.

3.2. Insurance benefits

3.2.1. The insurance shall cover health care services provided in Hungary only.

3.2.2. The insurance shall cover costs related to the insured's medically justified health care treatment as defined in these conditions provided that their justified use is properly supported by the insured.

3.2.3. The insurance benefit the insurance company shall pay to cover the costs of health care services under this insurance contract, shall be limited to limit specified in Section 1.14, and shall be reduced by deductibles, provided that the insurance company applies deductibles.

3.2.4. Within the framework of the outpatient treatment, the insurance company shall pay for:

- a) the costs of primary health care services,
- b) the costs of specialized health care treatment,
- c) the costs of a physician's field-work incurred when the insured's condition does not make it possible to visit the physician in his/her office (e.g. case of emergency),
- d) the costs of special tests (e.g. laboratory tests, X-ray diagnosis, ultrasound examination); which the insurance shall only cover if these are necessary for the exploration or treatment of the illness.)

3.2.5. Within the framework of inpatient treatment, the insurance company shall pay for the costs incurred from the insured's hospitalization and medical treatment. The insurance company, shall in particular pay for:

- a) the costs of medical treatments prescribed by a physician, (including necessary surgeries);
- b) the costs of nursing;
- c) the costs of medically justified abortion.
- d) the costs of services provided within the framework of antenatal care and child birth, provided that they are financed by Hungarian social insurance.

3.2.6. The insurance shall cover the costs of medications, bandage, temporary medical aids (products officially listed as medical aids) if required for the health care treatment, subject to and taking account of the limit and deductibles set out in Section 1.14.

3.2.7. Costs of travel or transport to a physician are covered by the insurance if they are within the territory of the country and such transport to the hospital (in an ambulance, taxi) is medically justified.

3.2.8. The insurance company shall cover the costs of repatriation (transport home) if the condition of the insured so requires or makes it possible and the medical service provider specified by the Insurance Company also recommends repatriation.

3.3. Payment of insurance benefits

3.3.1. The insurance company shall pay the costs of medical treatment received from, arranged by or delivered with the cooperation of the **designated health care service provider** directly to the designated health care service provider.

3.3.2. The Insurance Company shall pay the costs of **emergency health care services received from other than the designated health care service provider** in an emergency after consultation between the designated health care SP, the affected health care SP and the insured.

3.3.3. If the cost of a **pre-paid health care treatment is settled by the insured**, the insurance claim for recovering the costs of the health care service must be filed to the insurance company within 15 days from the issue of the invoice.

3.3.3.1. To enforce an insurance claim for covering the costs of any health care service, the following documents shall also be submitted to the insurance company:

- a) original invoices certifying payments, issued to the name and address of the Service Provider

b) a copy of all medical documents related to the insured event.

3.3.3.2. The designated medical service provider (ADENIUM J.V. Kft) shall pay to the beneficiary the amount shown on an invoice issued for a service prepaid by the insured after applying deductibles (costs of medication, medical devices purchases, medical examinations, medical treatment, etc.) only within 30 days of the issue date of the invoice provided that the claim is legally grounded. Adenium J.V. Kft. shall settle a legally grounded insurance claim within 15 days upon receipt of all the necessary medical documentation.

3.4. Exclusions

3.4.1. The insurance will not cover:

- a) consequences of any known illness, which pre-existed before the commencement of the insurance coverage or consequences of earlier accidents, or the permanent disability of the insured confirmed before the commencement of the coverage, with the exception of treatments in the scope of primary health care, not including the costs of medications and therapeutic aids ordered in treatments related to existing illnesses; furthermore, save for the case when the insured earlier had STÚDIUM insurance for several insurance periods and his/her illness which requires medical treatment was first diagnosed during such insurance periods provided that not more than 2 (two) months have passed between the commencement of the insurance coverage under the current policy and the termination of the previous insurance coverage.**
- b) hospitalization related to pregnancy and child delivery, if conception took place prior to the commencement of the insurance coverage applicable to the particular Insured. The insurance covers costs related to childbirth and hospitalization for childbirth if there is less than 285 days between the estimated due date – stated in a written verification by a physician – and the commencement of the insurance coverage applicable to the particular insured.**
- c) abortion of pregnancy (unless termination of the pregnancy was necessary to preserve the life or health of the mother, or if termination of the pregnancy was performed in a case where pregnancy was the result of a criminal act),**
- d) surgeries related exclusively to treating infertility, and medical treatments related to any form of artificial reproductive techniques,**
- e) sterilization surgeries and consequences,**
- f) sex reassignment surgeries,**
- g) treatments and surgeries exclusively for aesthetic (cosmetic) purposes,**
- h) eye correction surgeries,**
- i) dioptric glasses/sunglasses, contact lenses and their accessories,**
- j) hearing aid,**
- k) dental treatments, with the exception of fillings, root canal treatments, treatment of abscess, dental extractions, treatments of the mouth cavity (treatments of the gums, the mucous membrane, the salivary gland, aphta) up to the total of the limit specified for dental treatments.**
- l) health care services in relation to HIV infection,**
- m) tests taken and treatments performed in relation to the consumption of alcohol or narcotic drugs,**
- n) convenience (V.I.P.) health care services (e.g. single bedroom),**
- o) acupuncture, acupressure treatment, oriental medicine,**
- p) psychotherapy,**
- q) immunization shots,**
- r) treatment received in sanatoriums or in assisted accommodation,**
- s) rehabilitation or nursing of chronic illnesses (especially geriatrics, hospice care, special needs education, speech therapy, physiotherapy, physical therapy, bath therapy, weight loss therapy), excluding treatments which are for the purpose of diagnosing chronic illnesses, initiation of a therapy, the prevention of significant deterioration of acute conditions,**

t) medical care that is not for the purpose of diagnosing an illness of the insured (diagnostic tests), or for the prevention of a deteriorating condition or for the rehabilitation of the insured's health, in particular screening tests not ordered or attended in relation to this insurance, with the exception of an annual gynecologic screening (with cytology and a physical examination of breasts) for one occasion in every policy year, or a parent having to stay at a hospital with his/her child, nor is the insured's stay at a hospital for the purpose of nursing a parent,

u) treatment by a person who does not have medical certification and permit to practice medicine, and medical or other health care treatment made necessary as a result of treatments performed by such person.

3.4.2. Furthermore, the insurance will not cover events which are in part or in whole caused by any of the following:

- a) mental abnormality,
- b) HIV infection
- c) ionizing radiation,
- d) nuclear energy,
- e) warlike event, or a crime against the state.

For the purposes of these conditions warlike events shall mean war (whether war be declared or not), border conflicts, insurrection, revolution, riots, coup d'état or attempted coup d'état, civil war.

3.4.3. The insurance shall not cover insured events which may have been caused by the insured's engagement in sports activities with increased risks listed herein: scuba diving under 40 m, one-arm and open sea sailing, white-water rafting, hydrospeed, canyoning, surfing, mountaineering and rock-climbing from peg 5, high-mountain expeditions, caving and cave expeditions, bungee jumping, auto-motor sports (e.g. auto-crash, go-kart, moto-cross, motorboat sports, motorcycle sports, rally, ability competitions by car), quad, private flying/sports flying/aviation sports (e.g. paragliding, ballooning, motor sail plane, hang-gliding and ultra-light flying, hot-air ballooning, parachute jumping, free plane flying, stunt flying, base jumping.

3.5. Exemptions

3.5.1. The insurance company shall be exempt from payment of the insurance benefit if the insured event was caused by an unlawful and willful behavior of the policyholder or the insured or unlawfully and in gross negligence by them.

3.5.2. The Insured shall act in gross negligence, in particular, if

- a) the insured event occurred in relation to regular alcohol consumption, drug consumption, the administration of stupefying agents or medications by the insured, unless the latter was administered as prescribed by the attending physician,
- b) the insured was verifiably in an alcoholic condition at the time of the insured event, or was under the influence of drugs or stupefying agents and this fact intervened in the occurrence of the insured event. If a blood alcohol test was performed, blood alcohol concentration exceeding 1.5‰ – or 0.8‰ during driving a vehicle – shall be deemed as an alcoholic condition.
- c) the insured drove a motor vehicle without a valid traffic license or the insured did not have a valid driving license required for driving such vehicle, and this fact intervened in the occurrence of the insured event.
- d) the Insured has committed at least two traffic offences violating the traffic regulations effective in the particular country at the time of the occurrence of a traffic accident.

3.5.3. If the policyholder or the insured infringe their obligation to disclose or to report changes, the insurance company's obligation to pay the benefits shall not set in, unless it is proven that any of the following circumstances exist:

- a) the concealed or unreported circumstance was known to the insurance company at the time of concluding the contract; or
- b) the policyholder or the insured infringed their obligation to report changes, but the insurance company was made aware of such concealed or unreported circumstance during the term of

insurance, before an insured event, and the insurance company did not exercise its rights to amend or terminate the contract within 15 days, or

c) the concealed or unreported circumstance did not intervene in the occurrence of the insured event.

3.5.4. Should an insured event occur, the insured must act as generally expected in the given situation; accordingly, the insured must have recourse to prompt medical assistance and must keep to the instructions of the acting physician on an on-going basis until completion of the therapeutic procedure. If the insured has complied with his/her obligations to prevent and mitigate loss in accordance with this Clause, then the provision set forth in the last sentence of Clause 3.1.1 shall not be applied. The insurance company shall be exempt from its obligation to pay benefits to the extent that the insured did not comply with this obligation. This provision shall be without prejudice to the insured's right to freely choose a physician.

3.5.5. The verity of the circumstances listed must be evidenced by the party referring to them.

Section 4 Miscellaneous Provisions

4.1. Formal requirements and conditions for the validity of legal statements (notifications, reporting)

4.1.1. Legal statements of the parties to the insurance contract shall be valid only if made in writing, unless otherwise provided for herein. Written legal statements shall only be valid and enforceable against the insurance company if they are brought to the attention of an organizational unit of the insurance company. The insurance company shall be entitled to check legal statements faxed to it for their form and content.

4.1.2. If the insurance company sends a legal statement in registered mail to the last known address of the policyholder, the insured or any other person enforcing a claim, it shall be considered delivered when it is collected at the given address.

4.1.3. If the policyholder travels abroad for more than a month, and fails to notify the insurance company in writing about the particulars of his/her agent for service of process in Hungary, the insurance company may validly send legal statements to the last known address.

4.2. The lodging of complaints – complaints forum

4.2.1. Any complaint arising from or in connection with the insurance contract may be communicated to the Insurance Company orally (in person or over the phone at the Generali TeleCenter by calling 06-40/200-250) or in writing (in a document submitted in person or by an agent, or mailed to the Customer Relationship and Insurance Management Division of Generali-Providencia Biztosító Zrt., to its address (H-1066 Budapest, Teréz krt. 42-44) or faxed to 06-1/452-3927, or e-mailed to general@general.hu). <http://intranetportal/helyek/UKAKI>

4.2.2. The insurance company will investigate all filed complaints and shall give a notice to the complainant on the findings of such investigation within 30 days of the date when the complaint came to the attention of the insurance company.

4.3. Governing law and settlement procedure of legal disputes

4.3.1. The legal relationship established under the insurance contract between the Insurance Company and the Policyholder/Insured shall be governed by Hungarian law as well as the provisions set forth in these policy conditions, in the product information of STÚDIUM and in the Insured's Statement; matters not regulated therein shall be governed by the provisions of Act IV of 1959 on the Civil Code of the Republic of Hungary as well as the provisions of Act LX of 2003 on Insurance Institutions and the Insurance Business.

4.3.2. Any legal dispute arising from or in relation to the insurance contract or the legal relationship established under the contract concerning the violation, termination, interpretation or validity thereof, shall be exclusively referred to a competent court - dependent upon the disputed sum - with jurisdiction over the registered seat of the Insurance Company.

4.3.3. Communication between the Insurance Company and the Insured, as well as notices addressed to the Insureds shall be made both in Hungarian and in English, it being understood that in disputes or disagreement the Hungarian texts shall prevail.

4.4. Mediation proceedings

In order to settle out of court any financial consumer disputes arising from or in relation to the conclusion of the insurance contract or the payment of insurance benefits, customers may refer their cases to the Financial Arbitration Board operating within the Hungarian Financial Supervisory Authority (address: 1013 Budapest, Krisztina krt. 39.). Initiation of arbitration proceedings is subject to a previous attempt by the customer to resolve the disputed matter through direct negotiations with the Insurance Company. If the customer does not accept a decision of the insurance company with respect to payment of an insurance benefit, he/she may – in addition to Financial Arbitration Proceedings – initiate mediation proceedings which shall be carried out in compliance with effective legislation, and as a result the parties may agree to an out-of-court settlement of their dispute.

4.5. Information on the Concepts and Practice of Personal Data Management – Data Protection

Pursuant to the effective Hungarian legislation, the insurance company shall maintain confidentiality with regard to data disclosed to them as ‘confidential information related to insurance’ without any limit of time. Detailed provisions on the data management obligation of the insurance company are set forth in the Customer Information of Generali-Providencia Insurance Ltd, which shall be an integral part of these policy conditions.

4.6. Limitation

The limitation period of claims enforceable under the contract shall be one (1) year.