CHILDREN/STUDENT/YOUTH ACCIDENT INSURANCE REGULATIONS NO. BNGA 20

Approved at the meeting of the Management Board of Compensa Vienna Insurance Group ADB Latvian Branch on 16.06.2020.
Effective since 1st July 2020

Compensa Vienna Insurance Group ADB Latvian Branch (hereinafter in the Regulations – the Insurer), on the basis of these Regulations, enters into Insurance Contracts with natural persons and legal entities for Children's Accident Insurance.

1. DEFINITION OF TERMS

1.1. INSURER – Compensa Vienna Insurance Group ADB Latvian branch, registration number 40103942087, address: Vienības gatve 87H, Riga, LV-1004.

1.2. POLICYHOLDER – a natural person or legal entity who enters into an Accident Insurance Contract for his or her own benefit or for the benefit of another person.

1.3. INSURED – an infant, a minor child, a pre-school or school age child, a young person from birth to 17 (seventeen) years of age (inclusive), for the benefit of whom the Insurance Contract has been concluded (hereinafter – the Insured).

1.4. INSURANCE CONTRACT – agreement between the Insurer and the Policyholder on the Insurance Terms and Conditions, according to which the Policyholder undertakes to pay the Insurance Premium in the manner, terms and amount specified in the contract, as well as fulfil other obligations specified in the contract and the Insurer undertakes the obligation, upon the occurrence of the Insured Event, to pay the Insurance Indemnity to the person specified in the contract in accordance with the Insurance Contract, as well as to fulfil other obligations specified in the contract. The Insurance Contract consists of the Insurance Application (if submitted), the Insurance Policy, the appendices to the Insurance Policy, as well as the special Insurance Terms and Conditions, as well as any amendments or additions agreed between the Insurer and the Policyholder.

1.5. INSURANCE POLICY – a document certifying the conclusion of the Insurance Contract. The insurance policy is an integral part of the Insurance Contract.

1.6. INSURANCE REGULATIONS – terms and conditions of the Insurance Contract that apply to a specific Insured Object, which are specified in the Insurance Policy and are an integral part of the Insurance Contract. The Policyholder and the Insured undertake to comply with and execute them in order to receive the Insurance Indemnity upon the occurrence of the Insured Event.

1.7. INSURANCE PERIOD – the term of the Insurance Contract for which the Insurance Premium is paid and the Insurance Coverage is valid.

1.8. INSURANCE RISK – an event provided for in the Insurance Contract, independent of the will of the Insured or the Policyholder, the occurrence of which is possible in the future.

1.9. INSURANCE OBJECT – life or physical condition of the Insured, as well as material interests.

1.10. INSURANCE AMOUNT – the maximum monetary amount of the Insurer's liabilities specified in the Insurance Contract for each Insured risk in each Insurance 365 (three hundred and sixty-five) day period or for one Insured Event.

1.11. INSURANCE PREMIUM – payment for Insurance specified in the Insurance Contract.

1.12. INSURANCE EVENT – a sudden, unforeseeable event causally related to the Insured Risk, independent of the Insured's will, which occurred to the Insured during the Insurance Period as a result of external circumstances, and upon occurrence of which the Insurance Indemnity is paid and is considered an Accident in accordance with the Insurance Contract. In Civil Liability Insurance, the Insured Event is damage caused by the Insured to the health, life, physical condition of a third party, and/or material damage caused to a third party.

1.13. INSURANCE INDEMNITY CLAIM – the Insured's written application to the Insurer regarding the occurrence of the Insured's risk.

1.14. INSURANCE INDEMNITY – the amount of money payable for the Insured Event in accordance with the provisions of the Insurance Contract.

1.15. RELATIVES – for the purposes of these Regulations, relatives are the parents, children, spouse, adopted children and adoptive parents, grandparents and grandchildren, brothers, sisters, foster parents and foster children of the Insured.

1.16. RECIPIENT OF INDEMNITY – in case of occurrence of the Insured risks (except for Death risk) mentioned in the Insurance Policy, the Recipient of Indemnity is one of the Insured's parents, but in case of death of the Insured, the Recipient of Indemnity is the heir or heirs or Beneficiary, if specified in the Insurance Contract.

1.17. BENEFICIARY – a person specified in the Insurance Contract to whom the Insurance Indemnity or a part thereof is to be paid in the event of the death of the Insured. If the Beneficiary is not specified in the Insurance Contract, then the heir approved by the Insured in accordance with the regulatory enactments of the Republic of Latvia shall be considered the Beneficiary.

1.18. REPEATED INJURY – repeated tissue and organ damage acquired for an indefinite period of time.

1.19. REPEATED BONE FRACTURE – bone fracture suffered at a place of previous bone fracture of the Insured, which has occurred at the place of the previous bone fracture due to its incomplete healing.

1.20. PATHOLOGIC FRACTURE – bone fracture or meniscus rupture due to changes in the structure or strength of bones and/or cartilage.

1.21. HABIT DISLOCATION – traumatic injury that develops in one of the joints as a result of various degrees of physical trauma or is a consequence of an accident at work, which has been fostered by dangerous or harmful factors of the work environment.

1.22. ELEVATED RISK BONE FRACTURE – bone fracture or meniscus rupture caused by a previously injured joint, or a fracture due to a change in bone structure, osteoporosis, joint damage due to a background of damaged joint apparatus or degenerative changes.

1.23. CHRONIC DISEASE – gradual deterioration of physiological processes and functions of the body formed orally and over a long period of time, characterized by more frequent or less frequent deterioration of the state of health (exacerbations of the disease). In the context of these Insurance Regulations, according to the SSK10 classification, all diagnoses listed in the specified codes (A00–B99), except infections specified under Clause 17.1.1., (C00–D48), (D50–D89), (E00–E90), (F00–F99), (G00–G99), (H00–H59), (H60–H95), (I00–I99), (J00–J99), (K00–K93), (L00–L99), (M00–M99), (N00–N99), (O00–O99), (P00–P96), (Q00–Q99), (R00–R99) and (Z00–Z99) are classified as chronic diseases due to the fact that such diagnosed diseases may develop gradually and without visible/noticeable symptoms.

1.24. MUTILATION, DISABILITY – physical injury that has occurred to the Insured as a result of an Accident and has caused physical or functional damage or loss of a certain part of the body, complete and irreversible loss of vision, hearing or language.

1.25. MINOR BODILY INJURY – injuries that have not caused a health problem, but have caused only short-term, insignificant consequences. Minor injuries causing a temporary health problem are in the following cases: when a temporary health problem lasts from 7 days to 21 days.

1.26. DAY HOSPITAL – treatment in a hospital or outpatient clinic with a separate treatment unit for the provision of outpatient services and procedures for patients during the day (with a "day bed"), without staying in a medical institution for 24 hours, on weekends and holidays.

1.27. DEDUCTIBLE – the part of the financial participation of the Recipient of Indemnity (amount specified in the Insurance Contract) in each Insured Event, which is deducted from the amount of the Insurance Indemnity to be paid.

1.28. PATIENT CONTRIBUTION – a payment made by a patient upon receipt of state-paid health care services, for which the majority of costs are covered from the state budget.

1.29. OPTIONAL (HIGHER FEE) SERVICES – health care services that a patient can receive in public and private medical institutions without waiting in line for state quotas, but by paying the patient's contribution and an additional fee set by the medical institution for the specific service.

1.30. STATE QUOTA – state-paid health care services provided by medical treatment institutions to patients within the framework of the funding (quota) specified in an agreement with the state.

1.31. SPORT – a planned and purposeful set of physical activities performed by the Insured regularly over a long period of time in the form of training individually or in a team with or without an opponent and characterized by more or less frequent practical test of achieved results and/or participation in competitions to achieve a goal or maintain physical fitness.

1.32. PROFESSIONAL SPORT – engagement in sport, if this is the main occupation of the Insured and/or one of the sources of income, as well as if the Insured participates in a European or World Championships.

1.33. SPORTS ORGANIZATION – sports school, sports club or sports federation.

1.34. THIRD PARTY IN CIVIL LIABILITY INSURANCE – a natural or legal person who has suffered losses as a result of the Insured's actions and/or omissions and the Insurance indemnity is provided in accordance with the provisions of the Insurance Contract.

1.35. HARM TO HEALTH, LIFE, PHYSICAL CONDITION – injury or illness to third parties, whether or not the injury/illness is fatal.

1.36. MATERIAL DAMAGE – damage to the property of a third party or total or partial destruction of property.

1.37. CONSEQUENTIAL FINANCIAL LOSSES – financial loss directly resulting from damage to health, life, physical condition and or material damage.

1.38. PRINCIPLE OF COMPENSATION – insurance principle, according to which the Insurance Indemnity is calculated taking into account the actual expenses or loss incurred in the Insured Event, however, not exceeding the expenses or losses incurred in the Insured Event and the Insurance Amount.

2. ACCIDENT

2.1. An Accident is a sudden, unforeseeable, temporary exposure of the Insured's body to certain external factors (physical, mechanical, chemical, thermal, electrical) independent of the Insured's will where such exposure has taken place during the Insurance Period resulting in tissue and organ damage as a result of which incapacity for work and/or death occurs.

2.2. For the purposes of these Insurance Regulations, the following cases are also considered an Accident:

2.2.1. injuries sustained in a road traffic accident,

2.2.2. animal bite wounds,

2.2.3. infection from bites of animals and insects (hornets, wasps, bees), including tick-borne encephalitis, Lyme disease, typhoid and polio, as well as infection with rabies or tetanus due to traumatic tissue damage, where the infection has caused physical or functional loss of a part of the body, complete or partial loss of vision, hearing or language (provided that the Insured has received full vaccination within the prescribed time limits);

2.2.4. accidental, acute poisoning with poisonous plants, gas, chemical or toxic substances, if it has caused physical or functional loss of a certain part of the body, complete or partial loss of vision, hearing or language;

2.2.5. drowning;

2.2.6. asphyxia;

2.2.7. frostbite, burns;

2.2.8. lightning strike, exposure to electric current, if it has caused damage to certain parts of the body or organs;

2.2.9. injuries sustained as a result of exposure to various weapons, if the use of weapons has not been related to an illegal activity on the part of the Insured.

2.3. Age-related changes in the body, inflammation and diseases (diseases) are not considered an accident.

3. INSURANCE RISKS

3.1. The insured risks, taking into account the specifics of each Accident Insurance Policy, may be:

3.1.1. Basic risks:
- Bone fractures and injuries;
- Burns, frostbite;
- Mutilation, Disability;
- Death.

3.1.2. Additional risks:
- Hospital fee;
- Medical expenses;
- Tick-borne diseases;
- Animal, insect bites;
- Social care;
- Psychological help;
- Child's personal belongings (Bag insurance);
- Compensation for missed paid after-school classes;
- Accident Compensation (theatre or cinema ticket)
- Internet services;
- Civil liability insurance.

3.2. Additional risks specified in the Insurance Policy (except for civil liability insurance, psychological assistance, tick-borne diseases, animal, insect bites) shall be valid if the basic risk specified in the Additional Risk and referred to in the Insurance Policy have occurred at the same time as the Accident the occurrence of which shall be considered an Insured Event in accordance with the provisions of the Insurance Contract for which the payment of the Insurance Indemnity is provided.

3.3. The Insurance Contract shall be valid worldwide, unless otherwise specified in the Insurance Policy. If the Insurance Policy includes the risk of Medical Expenses, then this risk is valid only in the territory of the Republic of Latvia, except for the cases when the Insurance Contract risk "Medical Expenses" includes the sub-risk "Medical Expenses Abroad (in the Baltics)".

3.4. Bone fractures and traumas

3.4.1. In case of a bone fracture or injury, the Insured will be paid the Insurance Indemnity for the fact of the fracture or injury, if the fracture or injury is indicated in the Table of Bone Fractures and Injuries.

3.4.2. The amount of the Insurance Indemnity is calculated by multiplying the Insurance Amount by the indemnity percentage corresponding to the bone fracture or injury, which is indicated in the Insurance Indemnity Calculation Table of the respective bone fracture and injury.

3.4.3. If during the Insurance Period the Insured suffers several unrelated cases of bone fractures or injuries or several bone fractures or injuries are sustained in the same Accident, then the Insurance Indemnity shall be calculated for each of them, but the maximum Insurance Indemnity for one Accident or several Accidents together may not exceed the Insured Amount specified in the Insurance Policy for the Risk of Bone Fractures and Injuries during each 365 (three hundred and sixty-five) day period of the Insurance or another Insurance Period specified in the Insurance Policy.

3.4.4. If several positions in the Indemnity Calculation Table correspond to one injury or fracture, then the Insurance Indemnity is calculated according to the most severe fracture or injury.

3.4.5. The following is not considered an Insured Event and the Insurance Indemnity is not paid:

3.4.5.1. for pathological fractures, ruptures and repeated injuries (bone fractures, cartilage ruptures, sprains, tears and dislocations of ligaments, tendons, anastomoses and fascia), stress fractures if such position is not provided for in the respective Insurance Indemnity Calculation Table;

3.4.5.2. for intervertebral disc herniation, disc protrusion or vaulting; organ ruptures that have not occurred as a result of external injury;

3.4.5.3. on skeletal, muscular and connective tissue diseases and their exacerbations, injuries caused as a secondary consequence of these diseases (arthropathy, osteoarthritis, deforming and other dorsopathy, spondylopathy, osteopathy and chondropathy, as well as connective tissue system diseases according to the classification done by the Center for Disease Prevention and Control;

3.4.5.4. for injuries and fractures caused by auxiliary devices (transplants, implants, prostheses) inserted in the Insured's body.

3.5. Burns, frostbites

3.5.1. If as a result of the Accident the Insured has suffered body burns caused by high temperature, electric current or chemicals, the Insurer will pay the Insurance Indemnity on the basis of a certificate issued by the attending physician, State Burn Center or hospital, containing the following information:
- ratio of burn surface area to total body surface area;
- localization of burns;
- depth of damage.

3.5.2. The insurance indemnity in case of burns is calculated by classifying the damage according to the "Insurance indemnity calculation table in case of burns" by multiplying the respective percentage of the Insurance indemnity calculation base specified in the table by the damage indicated in the medical certificate, expressed as a percentage.

3.5.3. The insurance indemnity is paid starting from the 2nd degree burn, which is characterized by redness of the skin, pain, blisters formed on the skin and visible damage to the upper layers of the skin.

3.5.4. If frostbite is obtained as a result of external circumstances beyond the control of the Insured, the Insurance Indemnity is paid only for frostbite with deep tissue damage – necrosis.

3.5.5. The calculation of the Insurance Indemnity to be paid shall be performed in accordance with the indemnity percentage from the Insured Amount referred to in the "Indemnity Calculation Table in the Event of Frostbite".

3.5.6. The maximum Insurance Indemnity for one Insured Event and/or several cases together may not exceed the Insured Amount specified in the Insurance Contract for the Risk of Burns/Frostbite during each 365 (three hundred and sixty-five) day period or other Insurance Period specified in the Insurance Policy.

3.5.7. If bodily burns or frostbite have been caused as a result of the Accident and the Insurer has paid the Insurance Indemnity, but as a result of these burns, the Insured Person is recognized to have suffered Mutilation or Disability within 1 (one) year or death occurs within 1 (one) year, then the Insurance indemnity for the occurrence of death, mutilation or disability is calculated as follows:

3.5.7.1. if the Insurance Indemnity paid to the Insured for burns and/or frostbite is less than the Insurance Amount specified in the Insurance Policy in case of death or mutilation/disability, then the Beneficiary (in case of death of the Insured) or the Insured (in case of mutilation/disability) is paid the difference between the

Insurance Amount in case of death or mutilation/disability and the Insurance Indemnity already paid for the burn;

3.5.7.2. if the Insurance Indemnity paid to the Insured for burns and/or frostbite is equal to or greater than the Insurance Amount specified in the Insurance Policy in case of death or mutilation/disability, then no payment shall be made for the event of death or mutilation/disability.

3.5.8. The following is not considered an Insured Event and the Insurance Indemnity is not paid:

3.5.8.1. for grade I burn, characterized only by redness and pain;

3.5.8.2. for a burn that has not been diagnosed in the required format;

3.5.8.3. for superficial frostbite.

3.6. Mutilation, disability

3.6.1. The Insured Event occurs if as a result of an injury that occurred during the Insurance Period, the Insured suffers a physical health disorder, which is a direct consequence of the injury and due to which the Insured, within 12 (twelve) months after the Accident, sustains mutilation approved in accordance with the procedures established in the legislation of the Republic of Latvia, or a disability group is established.

3.6.2. The Insurance Indemnity is calculated by multiplying the Insurance Amount by the interest corresponding to the obtained mutilation in accordance with the "Irreversible Mutilation Insurance Indemnity Calculation Table".

3.6.3. The insurance indemnity for the suffered mutilation or disability is paid as a one-time payment after the first decision of the State Medical Commission for the Assessment of Health Condition and Working Ability on granting disability is received during the period referred to in Clause 3.6.1 of these Regulations.

3.6.4. If the Insured has suffered an Accident that occurred during the Insurance Period and as a result of this Accident the Insured's physical and/or mental abilities have deteriorated, the Insured's loss of ability to work is calculated as the difference between the loss of ability to work acquired before the Insurance Period and loss of ability to work.

3.6.5. Only one Insurance Indemnity is paid for an Accident – either for mutilation or disability, depending on which risk provides for a larger amount of the Insurance Indemnity.

3.6.6. The Insurance Indemnities previously paid in accordance with the same Insurance Contract for the risks "Bone Fractures, Injuries", "Burns, Frostbite" are deducted from the Insurance Indemnity due to mutilation or disability.

3.6.7. In cases when the Insured is granted a disability after the paid Insurance Indemnity for mutilation not later than within 1 year after the Accident, the Insurance Indemnity for Disability is reduced by the amount previously paid for the mutilation.

3.7. Death

3.7.1. The risk of death occurs if the physical health disorders caused to the Insured as a result of an injury during the Insurance Period have caused the death of the Insured within 12 (twelve) months from the date of the injury.

3.7.2. Upon occurrence of the Insured Risk "Death", the Insured Amount in the amount of 100 (one hundred) % provided for this Insured Risk in the Insurance Contract, minus the indemnities previously paid under this Insurance Contract for the risks "mutilation, disability", "fractures and injuries", "burns, frostbite", shall be paid.

3.7.3. If the Insured dies in an accident in a public vehicle, school bus, private car in a traffic accident, in case of a violent attack against the Insured or in the case of a criminal offense on the way to/from kindergarten (preschool child) or educational institution (school age child/young person), then the Beneficiary is paid twice the Insured Amount in the respective Insurance Policy in case of Death. This condition does not apply to the Insurance programs Extra+ and Extra++.

3.7.4. The insurance indemnity is not paid if the death of the Insured has not occurred as a result of injuries sustained in the Accident.

3.8. Hospital fee

3.8.1. Hospital fee is the Insurance Indemnity paid to the Recipient of Indemnity from the first day of the Insured's stay, if as a result of the Accident the Insured has been hospitalized for medical assistance, for an injury specified in one of the Insurance Indemnity Calculation Tables applicable to the concluded Insurance Contract, when the Insured has spent at least 24 (twenty-four) hours there.

3.8.2. The Insurance Indemnity for one day spent in a hospital and the maximum Insurance Amount during one 365 (three hundred and sixty-five) day period of the Insurance or during another Insurance Period specified in the Insurance Policy is specified in the Insurance Policy.

3.8.3. The Insurer calculates the hospital fee after the Insured leaves the hospital on the basis of the submitted documents on the hospital stay. The insurance indemnity is paid as one total amount for all days spent in the hospital.

3.8.4. The maximum period for which hospital money is paid for one Insured Event is 50 (fifty) calendar days, not exceeding the Insurance Amount during the Insured Period.

3.8.5. The insurance indemnity is not paid:

3.8.5.1. if the treatment time in a 24-hour hospital is less than 24 (twenty-four) hours;

3.8.5.2. for treatment or stay in sanatoriums, holiday homes, day hospitals and/or inpatient care departments, rehabilitation institutions.

3.9. Medical expenses

3.9.1. Medical expenses are reimbursed if the Insured has suffered an Accident in which a bone fracture or injury and/or burns, frostbite has occurred and for which payment of the Insurance Indemnity is provided in accordance with the Insurance Contract.

3.9.2. The Insurance Indemnity for treatment after single Accident or several Accidents together may not exceed the maximum Insured Amount specified in the Insurance Policy for the risk "Medical Expenses" during one Insurance 365 (three hundred and sixty-five) day period.

3.9.3. In each Insured Event, this Insurance Amount is limited to the Insurance Amount for one Insured Event, unless otherwise specified in the Insurance Contract. The Insurance Amount for one Insured Event is the maximum amount of Insurance Indemnities payable, which is paid for all types of medical expenses reimbursable in one case, referred to in Clause 3.9.6.1. if these types of medical expenses are specified in the Insurance Policy.

3.9.4. For each type of medical expenses, the Insurance Amount is determined, which is the maximum amount of the Insurance Indemnity payable for the specific type of medical expenses for one Insured Event.

3.9.5. The insured risk "Medical expenses" works in the Republic of Latvia, regardless of the territory of the Insurance Contract, unless otherwise specified in the Insurance Contract.

3.9.6. If as a result of the Accident the Insured incurs medical expenses within one year from the date of the injury, the Insurer shall reimburse the medical expenses, applying the compensation principle, but not exceeding the actual losses and the Insurance Amount for each of the types of medical expenses specified in the Insurance Contract for one Insured Event and for the entire Insured Period. The Insurance Contract may include the following types of medical expenses:

3.9.6.1. Outpatient and inpatient medical care:
3.9.6.1.1. Expenses of the Insured for the services of qualified medical specialists, which are provided on an outpatient or inpatient basis, if they have been prescribed by the attending physician, for example, consultations, laboratory tests, diagnostic examinations (X-rays, ultrasonography), blockages, injections, casting or fixing;

3.9.6.1.2. Physical therapy (physiotherapy) prescribed by the attending physician after an Accident, where the course of therapy for one Insured Event does not exceed 10 (ten) procedures with a maximum limit of EUR 10 (ten) per procedure for each Insurance 365 (three hundred and sixty-five) day period or other Insurance Period mentioned in the Insurance Policy.

3.9.6.2. Magnetic resonance imaging and computed tomography
Diagnostic examinations prescribed by the attending physician (computed tomography, magnetic resonance imaging) – both patient contributions and optional (increased fee) services.

3.9.6.3. Paid surgeries
Paid services in a 24-hour hospital in connection with the surgical treatment of the acquired injury.

3.9.6.4. Dentistry
Expenditure on the treatment of traumatic dental injuries (consultation, X-ray diagnostics, tooth extraction, medical and surgical treatment, local anaesthesia, dental prostheses and dental implants (50 (fifty) % of their actual costs)).

3.9.6.5. Rehabilitation expenses
Outpatient and inpatient rehabilitation services prescribed by the attending physician within 60 days after the inpatient treatment of consequences of the Insured risk "Bone Fractures and Injuries".

3.9.6.6. Medicines
Purchase of medicines registered in the Register of Medicinal Products of the Republic of Latvia by the attending physician, as well as dressings for the treatment of injuries.

3.9.6.7. Purchase or rental of technical aids
Purchase or rental of technical aids (crutches, wheelchairs, orthoses) prescribed by a doctor for the treatment of injuries.

3.9.6.8. Medical transport
Medical transport from the place of the accident to the nearest medical institution where the Insured is provided with the first emergency medical assistance.

3.9.6.9. Medical expenses abroad (in the Baltics)
Medical expenses for outpatient and/or inpatient emergency medical care (including medicines) for the prevention of an acute situation after an Accident, if the Accident occurred while the Insured was in Lithuania or Estonia.

3.9.6.10. Cosmetic surgeries
If after the occurrence of the risk "Bone Fractures and Injuries" and/or the risk "Burns, Frostbite" the Insurer has incurred expenses for plastic and microsurgical operations or manipulations necessary to correct and/or prevent mutilations caused by the Accident during the Insurance Period. The Insurer, applying the principle of compensation, shall reimburse the expenses under the following conditions:

3.9.6.10.1. the expenses have been incurred within 12 months from the date of the injury;

3.9.6.10.2. they are associated with permanent deforming skin damage to the head or neck, or permanent deforming body damage after burns, and are necessary for elimination of the consequences of the injury.

3.9.7. The following is not considered an Insured Event and the Insurance Indemnity is not paid:
3.9.7.1. for treatment outside the Republic of Latvia, except for expenses for risk "Medical expenses abroad", if the Insured Event has occurred in Lithuania or Estonia;

3.9.7.2. for medical expenses not related to the Accident;

3.9.7.3. for medical treatment expenses for which documents certifying the expenses have not been submitted;

3.9.7.4. for treatment in sanatoriums, holiday homes, day hospitals and/or inpatient care units;

3.9.7.5. for accommodation expenses related to rehabilitation in a rehabilitation institution – hospital stay, meals, etc.;

3.9.7.6. for complementary medicine services (e.g. manual therapy, Qigong physical and breathing exercise, Ayurvedic medicine, bioresonance (MORA) therapy, anthroposophical medicine, aromatherapy, occupational therapy and reiki services, osteopathy, etc.);

3.9.7.7. for implants, prosthetic orthopaedic services, prosthetic surgeries;

3.9.7.8. for the repair of prostheses, implants and/or seals;

3.9.7.9. for the treatment of deciduous teeth, except for first aid;

3.9.7.10. for the costs of treatment related to complications after the surgery;

3.9.7.11. for a fee for an upscale service room in medical institutions;

3.9.7.12. for treatment with medical technology and/or treatment method that is not registered in the State Register;

3.9.7.13. for sports medical services (muscle testing, doping control, EIROFIT methods-loads, motor readiness tests, etc.);

3.9.7.14. for royalty payments and other similar ancillary expenses.

3.10. Tick-borne diseases
3.10.1. Upon occurrence of the Insured Risk "Tick-Borne Diseases", the Insurance Amount in the amount of 100 (one hundred) % provided for this Insured Risk in the Insurance Contract shall be paid, provided that after the tick bite the Insured is diagnosed with the following:

3.10.1.1. tick-borne encephalitis, which is confirmed by a doctor-infectologist and the results of serological tests, as well as if the Insured has been hospitalized for at least 48 hours in connection with this disease;

3.10.1.2. borreliosis (Lyme disease), confirmed by a medical infectologist and confirmed by laboratory tests for IgM class against

Borrelia burgdorferi using the Western blot method. If these tests do not show OspC p25, which is a marker of recent infection, the Insured Event has occurred only if a repeat blood test, which is performed no earlier than 6 weeks after the date of the first tests, detects IgG class antibodies.

3.10.2. Insured risk "Tick-borne disease" takes effect on the 21st day from the date of entry into force of the Insurance Contract.

3.10.3. If the diagnosis is made or any symptoms of the respective disease appear before the 21st day from the date of entry into force of the Insurance Contract, the case shall not be recognized as an Insured Event and the Insurance Indemnity shall not be paid.

3.10.4. This Insured risk works even if the Insured has not been vaccinated against tick-borne encephalitis.

3.11. Animal, insect bites

3.11.1. The insurance indemnity is paid for:

3.11.1.1. bites of animals (snakes, dogs, cats, etc.), insects (hornets, wasps, bees). Bites of animals not belonging to the Insured's family, not scratches (dogs, cats, etc.);

3.11.1.2. In case of anaphylactic shock, treatment is provided in a 24-hour hospital and the diagnosis is determined by the attending physician.

3.11.2. When the risk "Animal, insect bites" occurs, the Insurance indemnity is paid, which is equal to the Insured risk sub-limit.

3.12. Social care

3.12.1. In case of group I disability or lost limb(s) suffered as a result of an injury, the Insurer, applying the compensation principle, will cover the Insured's costs:

3.12.1.1. for social care for the first 3 months from the date of the injury;

3.12.1.2. for reconstruction, rearrangement and equipping of the dwelling according to the special needs of the Insured, for example, but not limited to the following activities: expansion of doorways, floor adjustment, adaptation of sanitary facilities, installation of hoists, adjustment of electricity sources, purchase and installation of special height furniture.

3.12.2. Insurance indemnity:

3.12.2.1. the payment is made after the confirmation of the group I disability, if the Insured has applied for state social care assistance;

3.12.2.2. the costs of social care shall be covered on condition that the said service has been provided by a legal entity or an individual merchant who has registered for such business.

3.12.2.3. The total Insurance Indemnity payable may not exceed the Insurance Amount for this Insured Risk.

3.13. Psychological assistance

3.13.1. The risk occurs if after any of the 3.9.6. The risk occurs if after one of the cases described in Clause 3.9.6 the Insured needs psychological assistance.

3.13.2. Applying the principle of compensation, the costs of consultations of a psychotherapist in connection with the following cases that have occurred during the term of the Insurance Contract are covered:

3.13.2.1. death of the Insured's relatives (parents, brothers, sisters) as a result of an injury;

3.13.2.2. if after the occurrence of the Insured Event the Insured has been granted Group I disability for the first time;

3.13.2.3. physical violence, rape or sexual violence against the Insured;

3.13.2.4. Loss of the Insured's limbs (amputation) as a result of an injury, which must be recognized as an Insured Event within the meaning of these Regulations; facial mutilation.

3.13.3. Psychological assistance must be provided no later than within 1 month after the end of the term of the Insurance Contract;

3.13.4. It is the duty of the Insured, the Insured's parents, guardians or the Policyholder to apply to law enforcement authorities no later than within 48 hours after suffering physical or sexual abuse or rape.

3.13.5. The insurance indemnity for psychological assistance is paid not exceeding EUR 25 (twenty five) for the price of one visit and not exceeding the Insurance Amount for the risk "Psychological Assistance" specified in the Insurance Policy for one or more Insured Events.

3.13.6. The insurance indemnity is not paid:

3.13.6.1. if psychological assistance to the Insured was provided by a person who is not registered in the Register of Medical Practitioners and Medical Support Persons or the services have not been provided in accordance with the regulatory enactments of the Republic of Latvia and the procedures specified therein;

3.13.6.2. if the Insured, the Insured's parents, guardians or the Policyholder applied to law enforcement authorities later than within 48 hours after the physical or sexual abuse or rape;

3.13.6.3. if the Insured has suffered minor or minor bodily injury, except in cases of sexual violence.

3.14. Child's personal belongings

3.14.1. If the Insured suffers an Accident, as a result of which his/her bag (whether it is a backpack or a shoulder bag), items in the bag (textbooks, notebooks, stationery), personal clothing, sportswear, sports shoes, active recreation equipment (bicycle, skateboard, etc.), smartphone, tablet, laptop computer is reimbursed for the purchase of replacement items if the damaged items are not repairable, or for their repair if the items are repairable;

3.14.2. Damaged bag and damaged things, clothing must be presented to the Insurer upon request.

3.14.3. The Insurance Coverage is valid for those groups of items specified in the Insurance Contract, applying the sub-limits stipulated in the Insurance Contract.

3.14.4. Expenses for damaged items in the child's personal belongings are paid for each risk once in the Insurance Period, if an Accident has occurred, which in accordance with the Insurance Regulations is confirmed as an Insured Event for which the Insured is expected to receive the Insurance Indemnity.

3.15. Compensation for missed paid after-school classes

3.15.1. If the Insured has suffered an Accident for which the Insurance Indemnity is due in the context of these Regulations, and:

3.15.1.1. the treatment has been for at least 21 calendar days, the Insurer shall reimburse the expenses for the Insured's missed paid after-school classes;

3.15.1.2. the attending physician has forbidden to participate in the planned summer camps, which start within 14 days after the Accident, the Insurer reimburses irrecoverable expenses for delayed summer camps in the period from 20 May to 31 August of the calendar year, for which partial or full payment was made before the Insured Event occurred.

3.15.2. The insurance indemnity for delayed paid after-school classes and delayed summer camps after one single Accident or for several Accidents together may not exceed the maximum Insurance Amount specified in the Insurance Policy for the risk "Compensation for delayed paid after-school classes" during the Insurance Period.

3.16. Accident compensation – a theatre or cinema ticket

3.16.1. A theatre or cinema ticket is paid to the Insured if the Insured has suffered an Accident for which the Insurance Indemnity is due in the context of these Regulations and the treatment has been at least 14 calendar days.

3.16.2. A theatre or cinema ticket is paid once during the Insurance Period, regardless of the number of Insured Events.

3.16.3. The Insured Person must visit a theatre or cinema no later than within 2 (two) months after the occurrence of the Insured Event.

3.17. Internet services

3.17.1. If the Insured risks "Bone fractures and injuries" and/or the risk "Burns, frostbite" occur, as a result of which the Insured is placed in a 24-hour hospital for more than 24 consecutive hours, the Insurer reimburses the expenses for using the Internet while the Insured is in the hospital.

3.17.2. The insurance indemnity, applying the principle of compensation, is paid if the contract for the provision of Internet services has been concluded with the Insured and the Insured can document the expenses for the use of the Internet while in a hospital.

3.17.3. The total Insurance Indemnity payable may not exceed the Insurance Amount provided for this Insured Risk in the Insurance Contract.

3.17.4. The insurance indemnity is not paid if the Insured is in rehabilitation institutions.

3.18. Civil liability insurance

3.18.1. The Insurance Indemnity is intended for losses related to injury, mutilation or death or for damage to property caused by the Insured as a private person to a third party and for which the Insured is liable in accordance with the laws and regulations of the Republic of Latvia, provided that the liability has arisen as a result of the Insured's actions or omissions during the Insurance Period.

3.18.2. Civil liability insurance cover applies to the Insured's liability:

3.18.2.1. in relation to day-to-day risks (as a pedestrian, public service recipient, etc.);

3.18.2.2. resulting from daily visits of the Insured's specific educational institution for the purpose of obtaining education, staying in this educational institution and causing damage to a third person or educational institution;

3.18.2.3. arising from the Insured's active recreation (cycling, skateboarding, snowboarding, skiing, etc.);

3.18.2.4. arising from the Insured's participation in trainings and competitions while engaging in a specific sport, but provided that before concluding the Insurance Contract the Policyholder and the Insurer have agreed on the inclusion of the specific sport in the coverage and it is mentioned in the Insurance Policy;

3.18.2.5. for causing damage to third party pets; the cover does not apply to the keeping of wild and agricultural animals and livestock, as well as to the pets of the Insured, his/her family members and/or the Policyholder;

3.18.2.6. for damage caused by the Insured minor under the age of 18 to his/her employer, his/her movable and/or immovable property during the performance of work duties. The insurance cover is valid during the official working hours stipulated in the employment, training or company contract with the Insured Minor or his/her official guardian. Prerequisites for the validity of insurance coverage:

3.18.2.6.1. an official employment, training or company agreement has been concluded with the Insured Minor or his or her official guardian;

3.18.2.6.2. the Insured Event occurs in the period from May 21 to August 31 of the calendar year and is reported to the Insurer no later than by the end of the Insurance Period.

3.18.3. All losses and expenses arising from and relating to the same event or event are considered to be one Insured Event.

3.18.4. If several persons are jointly liable for the loss or damage, the Insurer shall indemnify only those losses or damages which have been proved and caused directly by the Insured and are causal in connection with the Insured's activities.

3.18.5. The insurance indemnity is not paid in the following cases:

3.18.5.1. for financial losses of any kind and nature;

3.18.5.2. if the Insured has caused loss or bodily injury to a third party while under the influence of alcohol or narcotic or toxic substances in any degree of intoxication;

3.18.5.3. if the legal liability is directly or indirectly related to the vehicle or other motor-driven equipment, land, air or water vehicle, while the Insured is driving it;

3.18.5.4. for losses to real estate (apartment, private house) where the Insured permanently or temporarily resides, and movable property in this property;

3.18.5.5. for losses caused by the Insured to persons consisting of close relatives (parents, brothers, sisters, grandparents) or other persons consisting of relatives or in-laws, if the Insured has a joint household with them;

3.18.5.6. for losses caused by the Insured during sports activities, causing damage/loss to a third party and his/her property, who is a member of the Insured's sports team or the opponent's team. A team member is understood to be a representative of a sports team and/or an opposing team who is involved in a particular sporting activity;

3.18.5.7. if the Insured causes loss or damage to himself or his property;

3.18.5.8. for any losses in connection and association with any lease agreement or any other agreement entered into by the Insured with a third party;

3.18.5.9. for losses that have repeatedly occurred due to the same reason that has previously caused losses that have been indemnified by the Insurer during the term of this Insurance policy or previous Insurance policy periods;

3.18.5.10. if the Insured deliberately acts unlawfully or with gross negligence causing damage to a third party;

3.18.5.11. for loss or damage covered by any other Insurance policy in force and issued before the effective date of this policy.

4. INSURED'S SPORTING AND ACTIVE RECREATION ACTIVITIES

4.1. If the Insured regularly engages in sports outside of sports activities in general education institutions (which are not sports schools) and/or other active recreation hobbies (sports schools, paid clubs, training, competitions), they must be marked Insurance policy in accordance with Clause 4.2.

4.2. Table of insured sports (The insurance policy must indicate the group of sports and/or a specific sports activity):

Name of sports group	Activities and conditions included in the cover	Types of sports
Recreational	Included in coverage	Sports activities in general education institutions (except sports schools), recreational activities in official, public recreation and amusement parks (including water parks and the Aerodium tunnel), board games, yoga, billiards, bowling, golf, minigolf, curling, cricket, fishing (except ice and inland or coastal waters), mountain hiking up to 3000 m and without special equipment, organized safari park visit, novuss, Nordic walking, recreational cycling (incl. mountain biking, except trial, BMX, downhill XCM and XCO), archery, shooting in a public shooting range, darts, snooker, skating (for recreational purposes)
Athletic	If the Insurance Policy contains an indication about the “Athletic” coverage, then the coverage also includes “Recreational” activities	Dancing (including sports dancing), gymnastics (including aerobics and its variants, CrossFit, street gymnastics), artistic gymnastics, orienteering (rogaining), squash, tennis, badminton, frisbee, volleyball, beach volleyball, basketball, football, fencing, roller skating, athletics, cross-country skiing, swimming, water polo, biathlon, equestrian, windsurfing, rowing (other than rafting), biathlon, table tennis, paintball, ballet, mask swimming (snorkelling), pétanque, tug of war, sailing (inland or coastal) waters, including yacht sailing), sled dog sports, streetball, floorball, speed skating, figure skating, field hockey, mini football, figure skating, modern pentathlon, scuba diving or diving (up to 9 m depth and accompanied by an instructor), fencing
Higher risk activities	If the Insurance Policy contains an indication about the “Higher risk activities” coverage, then the coverage also includes “Recreational” and “Athletic” activities	Ice hockey, go-karting, handball, lacrosse, downhill skiing, hunting, capoeira, polo, weightlifting, weightlifting, equestrian, highway cycling, cycling, duathlon, kayaking, canoeing, triathlon, kayaking, water skiing, American football, Bandy, bobsleigh, skeleton, luge, softball, short track, rollerblading, roller skating, inline
Extreme sport	If the Insurance Policy contains an indication about the “Extreme sport” coverage, then the coverage also includes “Recreational”, “Athletic” and “Higher risk activities”	Mountaineering, rock climbing, mountain climbing (more than 2500 meters above sea level), motorsport (including highway), BMX cycling, mountain biking, XCM, XCO (except downhill and trial) motorsport, rugby, skateboarding, snowboarding, slalom, skydiving, sandboarding, surfing, skiing, wakeboarding, kiteboarding

4.3. If a specific activity or sport is specified in the Insured’s Insurance Policy, it means that the Insurance Coverage in addition to the selected group of sports is valid for the Insured engaging in an additional activity or sport specified in the Insurance Policy regardless of the form of activity, but the Insurance Coverage is not valid for Professional Sports competitions or training sessions.

4.4. The insurance is not valid if the Insured is engaged in:

4.4.1. martial arts such as boxing, kickboxing, aikido, jujitsu, freestyle wrestling, Greco-Roman wrestling, judo no-rule martial arts, including MMA;

4.4.2. the following sports: speedboating, formulas, downhill, freestyle, freeride, bungee jumping, heleboarding, flying on aircraft (except as a passenger on an airplane) or flying equipment, longboarding, paragliding, rafting, speleology, Ski jumping, water sports (including water motorsports), scuba diving using an scuba gear, ice fishing or fishing on ice, winter swimming, scuba diving or diving deeper than 30 m (as well as engaging in this activity in the Arctic Ocean or adjacent seas), zorbing, expeditions;

4.4.3. sports that are not mentioned in the Insurance Regulations and the specific sport or group of sports not specified in the Insurance Policy.

4.5. Regardless of whether the said activity/sport is included in the Insured’s Insurance Coverage, the Insurance Indemnity will not be paid if any of the sports/activities include jumping from a height, gliding, acrobatics or rock climbing elements.

4.6. The Insurer may request additional information on the circumstances of the Accident in which the physical injury was acquired during sports activities.

4.7. Payment of the Insurance Indemnity may be refused if the Policyholder and/or the Insured have concealed or misled the Insurer about the Insured’s professional sports or activities with high-risk activities or sports, which are considered exceptions in accordance with these Insurance Regulations, for which the Insurance is not valid.

5. GENERAL EXCEPTIONS

According to these Insurance Regulations, it shall not be considered an Insured Event and the Insurer shall not have an obligation

to indemnify for losses if the losses have occurred as a result of the Insurance Exceptions.

5.1. If there is no additional special agreement in the Insurance Contract, then the Insurance protection is not valid for the following types of losses:

5.1.1. Terrorism – losses resulting from terrorism, terrorism means violence or dangerous activity that endangers human life, tangible or intangible property or infrastructure with the intention of influencing any government or keeping society or any part of it in fear;

5.1.2. War – resulting from a war invasion or war-like activity (whether declared or not), foreign enemy activity, military invasion, civil war, insurrection, revolution, riot, military or other usurpation of power;

5.1.3. Force majeure – caused by force majeure, natural disasters. Circumstances of force majeure shall be those circumstances which have been recognized as circumstances of force majeure by a legal act of the relevant state institution;

5.1.4. Intentional act, gross negligence – caused by malicious intent or the degree of fault of the Policyholder, the Insured or the injured Third Party, which in terms of indemnification and other civil consequences is comparable to malicious intent or when the Insured commenced an activity the harmfulness and danger of which could not and should not remain unknown to him/her;

5.1.5. Known losses or circumstances that may cause losses – losses or circumstances that may cause losses, that were known or that the Policyholder and/or the Insured should have known or that were clearly foreseeable at the time of concluding the Insurance Contract;

5.1.6. Repeated insured events – losses that have occurred repeatedly due to the same reason that has previously caused losses that the Insurer has indemnified during the term of this Insurance Contract or previous Insurance Contracts;

5.1.7. If the coverage of such losses is not provided for by national laws and regulations and/or special conditions of the Insurance Contract or special Insurance Regulations.

5.1.8. Losses incurred before the effective date of the Insurance Contract are not compensated.

5.1.9. Losses incurred after the expiry of the Insurance Contract shall not be indemnified, unless otherwise provided in the Insurance Contract.

5.2. In addition to the above-mentioned exceptions, the Insurer's obligations do not arise and the Insurance Indemnity for the Insured Risks referred to in the Insurance Contract is not paid:

5.2.1. if the Accident occurred while the Insured was under the influence of alcohol, any degree of intoxication of any narcotic or other substance, if it is causally related to alcohol intoxication or intoxication and the occurrence of the Insured risk or if the Insured's actions under the influence of alcohol or intoxication have contributed to the Insured risk;

5.2.2. if body damage, trauma and infection that cannot be diagnosed without visual diagnostics, specialized bacteriological and serological examination methods or surgical intervention (fractures, rupture of ligaments, damage to internal organs, brain injuries, infections) has not been confirmed by a doctor-specialist of the specific specialty;

5.2.3. for self-inflicted injuries, suicide or attempted suicide;

5.2.4. if the event has been caused by illegal actions of the Insured;

5.2.5. if the Accident occurred while the Insured was serving a sentence in a custodial institution or detention institution;

5.2.6. for circulatory disorders, bleeding in the brain, internal bleeding, except in cases when the said condition has occurred as a result of an Accident;

5.2.7. for bruises on the body without visible signs of injury;

5.2.8. for chronic diseases;

5.2.9. for human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and any of its derivatives, as well as other diseases, illnesses or damage to health, physical condition or life, caused or developed after infection with that virus, regardless of the cause and type of infection;

5.2.10. for hepatitis A, B, C;

5.2.11. if the cause of the Accident is a congenital disease diagnosed before the occurrence of the Insured Risk;

5.2.12. for the Insured's illness with an infectious disease or the deterioration of the Insured's general state of health, if the cause is not an Accident;

5.2.13. for insect bites (except for hornets, wasp, bee bite, if it has caused death, disability or anaphylactic shock and tick bites of the Insured); allergic reactions; sun exposure;

5.2.14. if a road traffic accident has occurred while the Insured is driving a vehicle:

5.2.14.1. without the right to drive a vehicle of the respective category;

5.2.14.2. a vehicle with the right to drive a vehicle of the respective category, but at a speed exceeding the maximum permitted driving speed specified in the requirements of the Road Traffic Regulations by 20 km/h and more; this exception does not apply if the Insured travels on closed tracks, accompanied by an experienced instructor;

5.2.15. if the event has occurred while the Insured is piloting any aircraft that does not belong to the airline and is not registered as a means of passenger transport, or while operating a non-powered aircraft, glider (with or without an engine) or hang glider;

5.2.16. if the incident occurred by parachuting or engaging in bungie jumping;

5.2.17. if the event occurred while driving a motorcycle with an engine capacity of more than 125 cm^3, scooter, jet ski (this exception is not valid if the Parties have agreed to exclude this clause from the Insurance Contract before the entry into force of the Insurance Contract and it is mentioned in the Insurance Policy as an additional condition);

5.2.18. if the case is caused by a psychical or mental disorder, the consequences of which are stroke, seizures, epilepsy or other spasmodic attacks; other chronic neurological disorders with impaired coordination or muscle weakness;

5.2.19. for cases that have occurred while the Insured is engaged in certain martial arts, as well as in high-risk activities and sports referred to as exceptions to Clause 4.4 of these Insurance Regulations;

5.2.20. if the Insured regularly engages in a sport, participates in trainings and competitions; this exception does not apply if the Insurance Policy states as an additional condition that the specific sports activities are included;

5.2.21. if the Insured participates in Professional sports competitions or training sessions;

5.2.22. if the Accident occurred due to reckless actions of the Insured, inappropriate from the standpoint of laws of logic and scientific knowledge, in conditions of increased danger and trauma and/or self-exposure to extreme danger or trauma, except in the case of saving a human life.

6. INFORMATION ABOUT INSURANCE OBJECT OR INSURED RISK

6.1. Before concluding the Insurance Contract, the Policyholder and/or the Insured is obliged to provide all the information requested by the Insurer, which is necessary for the Insurer to assess the Insured Risk. The Insurer processes the received information in order to assess the Insured risk and prepare the Insurance offer or the Insurance Contract.

6.2. The Policyholder and the Insured are responsible for the truthfulness and completeness of the provided information. Any falsification, incorrect and incomplete, distorted statement or omission may result in termination of the Insurance Contract or refusal to pay the Insurance Indemnity. The Insurer prepares its offer based on the information provided by the Policyholder and/or the Insured.

6.3. The Policyholder or the Insured is obliged to notify the Insurer about other valid Insurance Contracts that apply to the same Insurance Object.

7. CHANGES TO THE INFORMATION PROVIDED

7.1. The Policyholder and/or the Insured is obliged to immediately, as soon as possible, notify the Insurer in writing of all circumstances that may increase the probability of occurrence of the Insured risk or the amount of possible losses, as well as notify of any changes in the information provided in the Insurance Application.

7.2. After receiving additional information, the Insurer evaluates the increase of the Insured's risk, if the Insured's risk has increased, an additional Insurance premium is calculated and applied.

7.3. The insured risk has increased if the indicators forming the premium calculation specified in the Insurance Contract have increased by more than 15 (fifteen) %, in comparison with the initial ones.

7.4. Before concluding the Insurance Contract, during the term of the Insurance Contract or after the end of the Insurance Period, the Insurer has the right to inspect the Insured Object to make sure that there have been no changes in the initial risk information. However, this condition does not release the Policyholder and/or the Insured from the performance of the obligations specified in Clause 7.1 of these Regulations.

8. DUTIES OF THE POLICYHOLDER AND/OR THE INSURED

8.1. The Policyholder is obliged to inform the Insured that the Insured is Insured in accordance with a certain Insurance Contract, the conditions of which the Policyholder has agreed with the Insurer and the Insured are bound by these conditions, must observe and fulfil them, as well as explain to the Insured the consequences. in case the Insured fails to perform and/or improperly performs any of the provisions of the Insurance Contract.

8.2. By concluding the Insurance Contract, the Policyholder and/or the Insured undertakes to observe and fulfil all the requirements set by the Insurer, as well as to observe and fulfil additional requirements set by the Insurer in writing during the Insurance Period.

8.3. It is the duty of the Policyholder and/or the Insured to do everything possible to prevent accidents. It is the duty of the Policyholder and/or the Insured to immediately eliminate any noticed error/defect or to take such additional safety measures as the circumstances require.

8.4. In the event of an Accident, the Policyholder, the Insured's legal guardians, the Insured is obliged to ensure that the Insured is transported to the nearest medical institution to a qualified medical practitioner for medical assistance as soon as practicable, but not later than within 24 (twenty four) hours.

8.5. It is the responsibility of the Recipient of Indemnity to prove the fact and consequences of the Accident, to ensure the Insurer's claim to establish and assess the circumstances of the Accident, as well as to submit all information and documents requested by the Insurer and confirming it.

8.6. It is an obligation of the Recipient of Indemnity to give written consent to the Insurer, medical or medical institutions, local government or state institutions, if it is necessary for the issuance of medical documentation to the Insurer, including releasing the attending physicians from their duty of silence and, if necessary, authorizing the Insurer's representative to get acquainted with the Insured's medical documents relating to the possible Insured Event, its circumstances and the binding medical history.

8.7. The Recipient of Indemnity, the Insured is obliged to submit a certain written application to the Insurer or fill in the application on the Insurer's website www.compensa.lv within 30 days after the occurrence of the Accident in which the Insured has suffered. If due to objective reasons the Recipient of Indemnity, the Insured cannot personally submit a written application or fill in the application on the Insurer's website www.compensa.lv, then it shall be performed by the Insured's authorized person.

8.8. Upon the written request of the Insurer, the Insured agrees to perform an additional examination to assess his/her health condition in connection with a possible Insured Event. The costs of this additional inspection shall be borne by the Insurer.

8.9. In the event of an Accident as a result of illegal actions of a third party or road traffic accidents, the Insured is obliged to immediately inform the State Police and/or firefighters and/or other competent authorities as soon as possible.

8.10. The burden of proving the occurrence of the Insured Event rests with the Policyholder and/or the Insured, and in the event of the latter's death – with the Beneficiary or the Recipient of Indemnity.

8.11. The Insured, the Beneficiary or the heir shall, upon receipt of the Insurance Indemnity, transfer to the Insurer his/her claim rights against the person responsible for the loss in the amount of the paid Insurance Indemnity.

8.12. The Insurance Contract after the payment of the Insurance Indemnity shall remain valid until the end of the Insurance Period, taking into account the Insured Amount specified in the Insurance Contract for the specific Insured Risk, which has been reduced by the amount of the paid Insurance Indemnity.

9. CONSEQUENCES OF THE POLICYHOLDER'S AND/OR THE INSURED'S DEFAULT

9.1. If any action or omission of the Policyholder and/or the Insured has caused or will cause misleading the Insurer or

withholding the risk information, the Insurance Contract will be declared invalid from the date of its conclusion. The Insurer shall not reimburse the paid Insurance Premium.

9.2. The Insurer may reduce the indemnity payment to 50 (fifty)%, if the Policyholder and/or the Insured due to slight negligence:

9.2.1. has not fulfilled or has partially fulfilled any of the requirements specified in the Insurance Contract or the written requirements of the Insurer;

9.2.2. has in any way restricted the Insurer's ability to exercise its rights, including the Insurer's right to ascertain the circumstances of the occurrence of the Insured's risk, nuances and/or recourse, subrogation rights;

9.2.3. has violated any requirements of the regulatory enactment in force in the Republic of Latvia, which are applicable to the specific Insured Event. If the Insurance Contract includes the sub-risk "Medical Expenses Abroad (in the Baltics)" in the Medical Treatment Risk, the Insurance Indemnity shall not be paid if the Insured has violated the requirements of the regulatory enactment in force in the respective Baltic State.

9.3. The Insurer shall not pay the Insurance Indemnity if the occurrence of the risk has been caused by malicious intent or gross negligence of the Policyholder, the Insured or the Beneficiary; including due to the reasons specified under Clause 9.2. The Insurer shall not reimburse the paid Insurance Premium.

10. CONCLUSION AND ENTRY INTO FORCE OF THE INSURANCE AGREEMENT

10.1. The Insurance Contract consists of the Accident Insurance Policy, the Insurance Regulations, as well as amendments and supplements to this Contract, which have been agreed upon by the Parties to the Insurance Contract (hereinafter – the Parties) during the term of the Insurance Contract.

10.2. The rights and obligations of the Parties apply to the Insurer, the Policyholder and the Insured.

10.3. The Insurance Contract is concluded on the basis of the information provided by the Policyholder and/or the Insured in the Insurance Application. The Policyholder and/or the Insured (natural person) have the rights of a data subject within the meaning of the Data Processing Regulation 2016/679. The information received from the data subject is used for the preparation of the Insurance offer, conclusion of the contract and/or payment of the Insurance indemnity; the legal basis for data processing is a contract.

10.4. The Insurer may prepare the Insurance Offer before concluding the Insurance Contract. In case the Policyholder pays the Insurance premium indicated in the Insurance Offer to the Insurer's bank account, the Insurance Contract shall not be deemed concluded, unless otherwise specified in the Insurance Offer. In that case, the Insurance Premium is refunded to the payer of the Insurance Premium.

10.5. The Insurance Contract is considered concluded and enters into force on the next day after receipt of the Insurance premium or its part indicated in the invoice in the Insurer's bank account, but not earlier than on the first day of the Insurance Period specified in the Insurance Policy.

10.6. If the Parties agree in writing that the Insurance Premium (or the first part thereof) is paid after the date of concluding the Insurance Contract, then, if the Insurance Premium (or the first part thereof) is paid within the term and amount specified by the Insurer, the Insurance Contract shall be deemed entered into force in accordance with regulations of Clause 10.5.

10.7. If, contrary to what is indicated in the invoice, the Insurance Premium or the first part thereof is not paid within the specified term and amount, then it is considered that the Insurance Contract has not entered into force from the day of its conclusion. A separate notice that the Insurance Contract has not entered into force shall not be sent to the Policyholder and/or the Insured. The Insurer shall return the erroneous payment within 15 (fifteen) days from the date of receipt of the payment, if the settlement details where the payment is to be made can be determined.

10.8. Payment of the insurance premium or the first part thereof after the payment term indicated in the invoice does not oblige the Insurer to assume any obligations. The Insurer shall return the erroneous payment within 15 (fifteen) days from the date of receipt of the payment, if the settlement details where the payment is to be made can be determined.

10.9. The insurance contract is concluded in Latvian, in accordance with the laws and regulations in force in the Republic of Latvia. If the terms and conditions of the Insurance Contract have been translated and disagreements arise due to the translation, then the terms and conditions of the Insurance Contract in the Latvian language shall prevail.

10.10. When concluding the Insurance Contract using a means of distance communication, the same procedure for the entry into force of the Insurance Contract as when concluding the Insurance Contract at the Insurer's office shall apply.

11. TERMINATION OF THE INSURANCE CONTRACT

11.1. If, based on the written application of the Policyholder, the Insurance Contract is terminated before the end of the Insurance Period, the Insurer shall repay the unused Insurance Premium for the remaining period according to the statutory calculation, deducting 15 (fifteen)% and the previously paid Insurance Indemnity if such has been carried out during the operation of the Insurance Contract. If the balance of the premium is used to cover other payments to the Insurer, then no deductions are made from the premium.

11.2. If the current Insurance Premium payment has not been paid within the specified term and amount, the Insurer shall send a written notice to the Policyholder and/or the Insured about untimely and/or incomplete regular payment of the Insurance Premium with an invitation to pay the remaining part of the Insurance Premium.

11.3. If the Policyholder and/or the Insured fails to pay the Insurance Premium within the term and in the amount specified in the notice, the Insurer shall terminate the Insurance Contract without repaying the Insurance Premium for the period when the Insurance was valid. A separate notice that the Insurance Contract is terminated and the remaining part of the premium is not reimbursed shall not be sent to the Policyholder and/or the Insured.

11.4. The Policyholder is obliged to pay the Insurer the Insurance Premium or a part thereof for the period when the Insurance Contract was in force.

11.5. The Insurer or the Policyholder has the right to terminate the Insurance Contract unilaterally in the cases specified in the Insurance Contract Law, before the end of the Insurance Period, including after the occurrence of the Insured Event by sending a written notice to the other contracting party. The insurance contract is terminated on the 15th (fifteenth) day after sending the written notice.

11.6. If the Insurer has paid the Insurance Indemnity during the Insurance Period, the Policyholder must pay the Insurance Premium for the entire Insurance Period provided for in the Insurance Policy, if necessary, the Insurer has the right to deduct it from the Insurance Indemnity.

11.7. If the Insurance Indemnity has been paid during the Insurance Period and the Policyholder terminates the Insurance Contract before the expiry of the Insurance Contract or has not made the due payment of the Insurance Premium, then the Insurer has the right to issue an invoice for the remaining part of the Insurance Premium. The Policyholder is obliged to pay the invoice issued by the Insurer on time and in full.

11.8. Notwithstanding any other provision of this Insurance Contract, the Insurer shall not be deemed to provide the Insurance Coverage or make any payments or provide any services or benefits to any Insured and any other person to the extent that such cover, payment, service, benefit and/or any transaction or activity of the Insured violates the applicable sanctions, that is, all trade, financial embargo or economic sanctions, laws or regulations directly applicable to the Insurer. The applicable sanctions are as follows: (I) domestic sanctions; (II) the European Union (EU); (III) the United Nations (UN); (IV) United States (USA) and/or (V) all other sanctions applicable to the Insurer.

11.9. The Insurer is entitled to terminate the Insurance Contract unilaterally by notifying the Policyholder in writing if the sanctions imposed by the United Nations, the European Union or the United States authorities during the term of the Insurance Contract directly or indirectly deter the Insurance Company from performing such Insurance Contract. Such written notice of termination of the Insurance Contract shall enter into force on the 15th (fifteenth) day, counting from the moment when the Insurer has sent such notice to the Policyholder.

11.10. The Insurance Contract may be terminated before the end of the Insurance Term by mutual written agreement of the Parties.

12. DOCUMENTS TO BE SUBMITTED TO EXAMINE THE INSURANCE EVENT

12.1. In order to assess and establish whether an Insured Event has occurred, the Recipient of Indemnity must submit to the Insurer:

12.2. a) an electronic application in a form specified by the Insurer regarding the occurrence of the Insured's risk (to be filled in at www.compensa.lv);

12.3. b) at the request of the Insurer – other documents proving the occurrence of the Insured Event.

12.4. In addition to the documents referred to in Clause 12.1, the Recipient of Indemnity must also submit the following documents regarding the occurrence of the specific Insured Risk:

Insurance risk	Documents to be submitted
Bone fractures and injuries	• A medical certificate issued by a specialist doctor, which indicates the type of injury or bone fracture and defines the exact diagnosis. Imaging conclusions of imaging diagnostics (X-ray, ultrasonography, magnetic resonance, computed tomography).
Burns, frostbites	• A medical certificate issued by the attending physician, the State Burn Center or a hospital, in which the degree of burns or frostbite of the body is indicated.
Mutilation, disability	• Conclusion of the State Medical Commission for the Assessment of Health Condition and Working Ability, which confirms the establishment of a disability group (in case of disability) or the recognition of mutilation (in case of mutilation); • At the request of the Insurer – documents on the basis of which a disability group has been granted or a specific degree of mutilation has been approved.
Death	• A copy of the death certificate (presenting the original); • A document certifying the beneficiary's right to receive the Insurance Indemnity (for example, inheritance certificate, court decision on the right to inheritance, etc.); • The results of the autopsy of the corpse, except in the case when the death has occurred while the Insured is in hospital.
Medical expenses	• A certificate issued by a medical institution, indicating the type of injury or bone fracture, exact diagnosis, recommended treatment, indicating the name, surname, personal identification code of the Insured, the name of the received service (even if the doctor has indicated treatment with over-the-counter medicines in the extract); • Documents confirming the payments, which must indicate a transcript of medical manipulations, purchased goods, names of medicines or services received and the name, surname and personal identification number of the Insured; • A certificate confirming the doctor's instructions to use a technical aid; in the case of the lease of technical aids – the lease agreement; • Copies of prescriptions.

Hospital day fee	• A statement from a medical institution stating the duration of inpatient treatment.
Tick-borne diseases	• A statement from a medical institution stating the duration of inpatient treatment; • Results of examinations in accordance with Clause 3.10. of these Regulations.
Animal, insect bites	• A specialist medical certificate stating the exact diagnosis or hospital statement – epicrisis.
Social care	• Conclusions by the State Medical Commission for the Assessment of Health Condition and Working Ability on the establishment of a disability group; • A statement from the social service confirming that the Insured has applied for state social care assistance; • In case of receiving the services of a social caregiver – documents confirming the payment, in which the documents provided to the Insurer are indicated; • In case of housing reconstruction – estimate of construction works, list of reconstruction works, documents confirming the purchase of materials and goods, as well as payment for the performed construction works, photos before and after the construction works (at the request of the Insurer).
Psychological care	• Conclusions by the State Medical Commission for the Assessment of Health Condition and Working Ability on the establishment of a disability group or a document of a law enforcement institution confirming the occurrence of the case, or the documents listed under the Insured risk "Death"; • A document confirming the payment, in which the name, surname and personal identification number of the recipient of the service and a description of the received service are presented; • A document certifying the degree of kinship.
Child's personal belongings	• A medical certificate from a specialist doctor stating the type of injury or bone fracture and the exact diagnosis; • A list of bags and/or damaged items/objects damaged as a result of the accident with an approximate purchase price; • Copies of receipts confirming the repair of damaged bags and/or items or the purchase of new bags and/or items; • Pictures confirming that the Insured's items are damaged.
Compensation for missed paid after-school classes	• Medical certificate of a specialist doctor, which indicates the exact diagnosis and exemption from the educational institution or hospital statement – epicrisis; • Proof of payment – the original of the electronic cash register check and/or the registered accounting receipt and/or the payment order, which must indicate: the name of the service provider, registration number, registered office; Name, surname, personal identification number of the Insured; the name and price of the group or camp, the date of purchase; • Agreement with the organizer of the after-school classes or camp; • Confirmation of the organizer of the after-school classes or camp about the returned/non-refundable participation fee.
Accident compensation – a theatre or cinema ticket	• A medical certificate from a specialist doctor stating the exact diagnosis and period of treatment or a hospital discharge-epicrisis; • Proof of payment – check or payment order; • A theatre or cinema ticket.
Internet services	• A statement from a medical institution stating the duration of inpatient treatment; • Internet service provider agreement, invoice for the provided services with a transcript and proof of payment.
Civil liability insurance	• Objections of the victim third party

13. PAYMENT PROCEDURE OF THE INSURANCE INDEMNITY

13.1. The Insured or the Insured's representative is obliged to submit to the Insurer a certain form of the Insurance Indemnity Claim Application and other documents in order to establish whether the reported Accident is an Insured Event and to determine the amount of the Insurance Indemnity.

13.2. The decision on the payment of the Insurance Indemnity shall be made not later than within 30 (thirty) days after receipt of all the requested documents and necessary for the evaluation of the Insured Event.

13.3. Payment of the insurance indemnity may be refused if the Insured or the Beneficiary does not submit or refuses to submit the documents requested by the Insurer.

13.4. If the occurrence of the Insured Event is established and the Parties have agreed on the amount of the Insurance Indemnity, then:

13.4.1. The Insurer makes a decision on the payment of the Insurance Indemnity;

13.4.2. The Insurer shall pay the Insurance Indemnity to the Insured or the Beneficiary (unless otherwise specified in the Insurance Policy) within 5 (five) business days after the decision on the payment of the Insurance Indemnity has been made;

13.5. If the occurrence of the Insured Event is established, but the parties cannot agree on the amount of the Insurance Indemnity:

13.5.1. The Insurer has the right to request additional documents for determining the amount of the Insurance Indemnity;

13.5.2. The Insurer has the right to unilaterally decide on inviting an expert to determine the amount of the Insurance Indemnity. The conclusion of the expert invited by the Insurer will be binding on both the Policyholder and the Insured;

13.5.3. In evaluation of the expert opinion, the Insurer shall make a decision regarding the amount of the Insurance Indemnity or another disputed issue.

13.6. If the Insured Event is not established:

13.6.1. then the Insurer shall make a decision regarding the refusal to pay the Insurance Indemnity;

13.6.2. the Insurer shall notify the Policyholder and/or the Insured about the decision within 5 (five) business days after the decision is made.

13.7. Before paying the Insurance Indemnity, the Insurer may request:

13.7.1. repeated conclusion of the medical examination commission;

13.7.2. information regarding the level of alcohol concentration in the blood of the Insured at the time of the Accident;

13.7.3. verification of the validity of the doctor's report and other documents;

13.7.4. other documents necessary for the assessment of the Accident and/or calculation of the Insurance Indemnity.

13.8. The insurance indemnity is paid in accordance with the indemnity calculation table indicated in the Insured risk or according to the compensation principle, if it is indicated for the specific risk.

13.9. If a split payment is applied to the Insurance Premium, then the Insurer has the right to deduct from the Insurance Indemnity to be paid the difference between the paid and full Insurance Premium.

14. APPLICABLE LAWS AND PROCEDURE OF SETTLEMENT OF DISPUTES

14.1. The parties will apply the regulatory enactments in force in the Republic of Latvia, including the norms specified in the Insurance Contract Law, to regulate the contractual relations arising from the Insurance Contract.

14.2. If the parties fail to resolve the dispute through negotiations, then a written complaint must be submitted to the "Compensation Commission", postal address: Vienības gatve 87H, Riga, LV-1004; e-mail address: atlidzibas@compensa.lv. The Insurer shall review the complaints of the Policyholder, the Insured or another person who has the right to claim the Insurance Indemnity and provide a response within 20 (twenty) days from the date of receipt of the complaint or claim. If it is not possible to provide an answer within the specified term due to objective reasons, the Insurer shall provide information on the necessity of extension and indicate a reasonable term when the answer will be provided.

14.3. A natural person – the Policyholder, the Insured or a third party has the right to submit a complaint to the Ombudsman of the Latvian Insurers' Association in accordance with its Regulations. The procedures (regulations) approved by the Latvian Insurers' Association are available at www.laa.lv.

15. INFORMATION ON PERSONAL DATA PROCESSING

15.1. The Insurer processes the received information in accordance with the regulatory enactments in force in the Republic of Latvia, including in accordance with the Data Regulation 2016/679.

15.2. Pursuant to Article 13 of the Data Regulation 2016/679, the Insurer, before concluding the Insurance Contract, informs the data subject (the Policyholder) that:

15.2.1. the data processing controller is Compensa Vienna Insurance Group ADB Latvian Branch;

15.2.2. the contact information of the data processing controller is as follows: info@compensa.lv, (+371) 6755 8888;

15.2.3. the contact information of the data protection officer is as follows: DPO@compensa.lv;

15.2.4. the data is processed in order to conclude the Insurance Contract, monitor its performance during the term of the Insurance Contract and pay the Insurance Indemnity; legal basis for data processing – the Insurance Contract concluded between the parties;

15.2.5. the data are also processed for other purposes if the data subject has given his or her consent; the legal basis for data processing – the consent of the data subject;

15.2.6. the data subject has the right, at any time, to withdraw the given consent to the processing of personal data in writing;

15.2.7. the legitimate interest of the data processing controller – after the conclusion of the Insurance Contract or the payment of the Insurance Indemnity to receive feedback from the data subject;

15.2.8. categories of recipients of personal data – in respective cases specified by law – state and local government institutions; medical treatment institutions, more information can be found on the Insurer's website https://www.compensa.lv/privacy-policy/;

15.2.9. in certain cases, personal data may be transferred outside the EEA; legal basis – saving the health or life of a person (data subject);

15.2.10. the term of storage of personal data – depending on the specifics of the Insurance Product, the terms of storage specified in the Insurance Regulations and special laws;

15.2.11. the personal data subject has the right to request information regarding the processing of the personal data of the data subject with the Insurer;

15.2.12. the data subject has the right to submit a complaint regarding the data processing controller to the State Data Inspectorate www.dvi.gov.lv, info@dvi.gov.lv;

15.2.13. the data subject is obliged to provide personal data in order to enter into the Insurance Contract to pay the Insurance Indemnity; in case the data requested by the Insurer is not provided or is provided incompletely, the Insurer is not entitled to pay the Insurance Indemnity (in accordance with Article 31 of the Insurance Contract Law); this condition also applies to personal data of a special category (health);

15.3. The Policyholder is obliged to inform the Insured(s), not later than within one month, that the personal data of the Insured persons (data subjects) are transferred to the Insurer – for what purposes, to what extent they will be processed; what consequences may occur if the Insured have provided inaccurate or incorrect personal data;

15.4. The Policyholder is obliged to inform the Insured(s) not later than within one month that the personal data of the Insured persons (data subjects) will be used for communication with the data subjects in case of data incident and indemnity payment.

16. MISCELLANEOUS

16.1. The Insurance Contract may be amended by separate written agreement of the Policyholder and the Insurer.

16.2. When paying the Insurance Indemnity, the Insurer has the right of claim against the person responsible for the caused losses in the amount of the Insurance Indemnity paid. The Insurer may not file a recourse claim against the Insured's children, parents or spouse. Exceptions are those Insured Events caused by negligence, malicious intent or gross negligence.

16.3. If the Policyholder or the Insured waives its claim against a third party or waives the rights giving rise to such claim, the Insurer shall be released from its contractual obligations to the extent that it could have claimed the covered Insurance Indemnity based on this claim or these rights.

16.4. The Insurer shall not disclose to third parties information about the Policyholder and the Insured, except for the cases specified in the legal acts of the Republic of Latvia.

16.5. During the term of the Insurance Contract, the Insurer communicates with the Insured and the Policyholder in Latvian, as well as responds to the requests of the Insured and the Policyholder expressed in Latvian.

16.6. The Insurance Contract Law, the Civil Law and other regulatory enactments of the Republic of Latvia are applied to regulate the relations arising from the Insurance Contract.

17. INDEMNITY CALCULATION TABLES

INSURANCE INDEMNITY CALCULATION TABLE IN CASE OF BURNS

Degree of damage	Burn degree	Classification criteria	Base %*
Minor damage due to burns	II burn degree	1–<15 % for adults <40 years of age 1–<10 % for adults >40 years of age 1–<10 % for children <10 years of age	2
	III burn degree	<2 % without cosmetic or functional defect	
Moderate damage due to burns	II burn degree	15–25 % for adults <40 years of age 10–20 % for adults >40 years of age 10–20 % for children <10 years of age	3
	III burn degree	<10 % without cosmetic or functional defect in case of face, eyes, ears, hands, feet, perineum	
Severe damage due to burns	III burn degree	>25 % for adults <40 years of age >20 % for adults >40 years of age >20 % for children <10 years of age or >10 % for a person of any age or damage to the face, eyes, ears, hands, feet, perineum with consequent functional or cosmetic defects, or burns caused by high-voltage electricity, or damage of any kind, including inhalation damage	4

* The insurance indemnity is calculated by classifying the burn according to the Degree of Damage and the Degree of Burn, multiplying the respective percentage of the classification criterion by the base percentage.

INSURANCE INDEMNITY CALCULATION TABLE IN CASE OF FROSTBITE

Frostbite with necrosis	Insurance indemnity% of the Insurance Amount
Frostbite of one finger	5
Frostbite of five fingers of one hand	25
Freezing of one hand	50
Freezing of one hand and wrist	55
Freezing of one toe	3
Frostbite of five toes of one leg	20
Frostbite of one feet	60
Frostbite of one feet and leg up to knee	80
Grade II ear, nose or face frostbite	1–5

IRREVERSIBLE MUTILATION INSURANCE INDEMNITY CALCULATION TABELE

Mutilation, disability	Insurance indemnity% of the Insurance Amount	
Complete loss of vision in both eyes, as well as a condition where, after correction, vision is 3/60 or less on the Schnell scale	100	
Complete, incurable madness (dementia)	100	
Complete loss of both palms or hands	100	
Total deafness of traumatic origin in both ears	100	
Lower jaw amputation	100	
Complete loss of language	100	
Complete loss of one arm and leg	100	
Complete loss of one arm and one foot	100	
Complete loss of one hand and one foot	100	
Complete loss of one hand and one leg	100	
Complete loss of both legs	100	
Complete loss of both feet	100	
Granting of the disability status "Disabled child" as a result of an accident	100	
HEAD		
Loss of skull bone throughout the surface thickness • surface over 6 cm^2 • surface 3–6 cm^2 • surface less than 3 cm^2	 40 20 10	
Partial mandibular amputation, complete or partial maxillary bone damage	40	
Complete loss of one eye	40	
Complete deafness in one ear	30	
Complete and irreversible loss of smell or taste	5	
Complete loss of tongue of traumatic origin	70	
UPPER LIMBS	**Lead***	**Non-lead***
Loss of one hand or palm	60	50
Significant loss of hand bone mass (definite and incurable damage)	50	40
Complete paralysis of the upper extremity (incurable nerve damage)	65	55
Complete paralysis of the musculocutanous nerve	20	15
Ankylosis of the shoulder joint	40	30
Ankylosis of the elbow joint • in a physiologically good position (15% at right angles) • in a physiologically poor position	 25 40	 20 35
Massive loss of both bones of the forearm (existing and incurable damage)	40	30

Complete median nerve palsy	45	35
Complete paralysis of the radial nerve, with a drooping palm	40	35
Complete paralysis of the forearm radial nerve	30	25
Complete paralysis of the arm radial nerve	20	15
Complete paralysis of the ulnar nerve	30	25
Ankylosis of the wrist in a physiologically good position (upright and pronation)	20	15
Ankylosis of the wrist in a physiologically unfavourable position (flexion, excessive extension or supination)	30	25
Complete loss of thumb	20	15
Partial loss of thumb (nail phalanx)	10	5
Complete thumb ankylosis	20	15
Complete loss of index finger	15	10
Complete loss of two phalanxes from the index finger	10	8
Complete loss of forefinger phalanx	5	3
Simultaneous loss of thumb and forefinger	35	25
Complete loss of thumb and any other finger (except index finger)	25	20
Complete loss of two fingers (excluding thumb and forefinger)	12	8
Complete loss of three fingers (excluding thumb and forefinger)	20	15
Complete loss of four fingers, including the thumb	45	40
Complete loss of four fingers except the thumb	40	35
Complete loss of the middle finger	10	8
Complete loss of any finger (except thumb, forefinger or middle finger)	7	3
Loss of nail phalanx of any finger except index finger and thumb	2	1

LOWER LIMBS

Complete loss of leg	60
Complete loss of the leg up to the thigh	50
Complete loss of the foot (tibiotarsal joint – ankle joint)	45
Partial foot loss (distal to the ankle joint in submalleolar disarticulation)	40
Partial foot loss (medio-tars disarticulation)	35
Partial loss of foot (tarso-metatarsal joint)	30
Complete paralysis of the lower extremity (incurable nerve damage)	60
Complete paralysis of the sciatic nerve of the outer thigh	30
Complete paralysis of the sciatic nerve of the inner thigh	20
Complete 2 nerve palsy (outer and inner lower leg buttocks)	40
Hip ankylosis	40
Knee ankylosis	20
Loss of hip bone or loss of both bones in the lower leg (incurable condition)	60
Loss of bone mass in the knee joint with significant bone fragmentation and difficulty in tensioning and stretching the leg	40
Loss of bone mass in the knee joint while maintaining movement	20
Shortening of the lower limb by at least 5 cm	30
Shortening of the lower limb by 3–5 cm	20
Shortening of the lower limb by 1–3 cm	10
Complete amputation of toes	25
Amputation of four toes, including the big toe	20
Complete loss of four fingers except the big toe	10
Complete loss of the big toe	10
Complete loss of two fingers	5
Finger amputation	3

For the ankylosis of the Insured's finger (excluding thumb and forefinger) and toe (except thumb), the Insured receives 50 % of the amount of the Insurance Indemnity, which should be received in case of loss of these limbs.

BONE FRACTURE AND INJURY INSURANCE INDEMNITY CALCULATION TABLE

No, Bone fracture or injury	Comp. %
I. SKULL, CENTRAL AND PERIPHERAL SYSTEM	
1. Fracture of the back (brain) of the skull:	
1.1. fracture of the outer plate of the vault bones	10
1.2. vault bone fracture	15
1.3. bases	25
1.2. fracture of the base and arch bone	45
2. Brain injury:	
2.1. concussion with outpatient treatment for more than 10 calendar days	1
2.2. concussion with inpatient treatment	
2.2.1. 4–7 calendar days	2
2.2.2. not less than 7 calendar days	3
2.2.3. longer than 14 calendar days	5
2.2.4. longer than 21 calendar days	7
2.3. concussion	15
2.4. concussion of the brain with contusion of the brain	35
3. Intracranial traumatic hemorrhage:	
3.1. epidural hematoma	10
3.2. subarachnoid hematoma	15
3.3. subdural hematoma	20
3.4. intracerebral hematoma	25
4. Nerve damage:	
4.1. damage to the peripheral nerves of one or more brains	10
4.2. traumatic spinal cord injury:	
4.2.1. bleeding in the spinal cord due to concussion, contusion, sprain, compression	10
4.2.2. complete rupture of the spinal cord	90
4.3. damage to the neck, arms, waist and sacrum	
4.3.1. nerve plexus contusion	4
4.3.2. traumatic plexitis	8
4.3.3. partial rupture of the nerve plexus	20
4.3.4. complete rupture of the nerve plexus	30
4.3.5. rupture of a nerve at the level of the fingers, foot or wrist	4
4.3.6. nerve rupture at the forearm, lower leg level	10
4.3.7. nerve rupture at the level of the upper arm, elbow joint, thigh	30
5. Traumatic damage to the bones of the front (face) of the skull:	
5.1. mandibular dislocation	1
5.2. mandibular fracture	5
5.3. fracture of the anterior wall of the maxilla, cheekbone, orbit or forehead	8
5.4. fracture of the nasal bone or cartilage	2
5.5. traumatic tooth fracture, except deciduous teeth (front 4 teeth – 2% each, other teeth – 1% each)	1–2
5.6. partial or complete loss of the mandible	30–50
II. SPINE	
1. Fracture or dislocation of the body, arch and joints of the vertebrae of the spine, excluding the tailbone (10% in the case of multiple fractures)	5
2. Fracture of transverse or pointed growth of vertebral column (6% in case of multiple fractures)	3
3. Fracture of the sacrum	10
4. Tail vertebral fracture	5
5. Complete rupture of intervertebral ligaments	5
6. Tension of intervertebral ligaments	1
III. SHOULDER JOINT, UPPER ARM, FOREARM, WRIST	
1. Sprain of shoulder, sternoclavicular, acromioclavicular joint ligaments	1
2. Fracture of clavicle or shoulder blade, rupture of acromioclavicular or sternoclavicular joint	3
3. Shoulder joint tendon, joint capsule rupture, bone fragment rupture, joint dislocation (in case of repeated dislocation 2%)	5
4. Upper arm fracture (14% in case of double fracture)	11
5. Intra-articular fracture of three bones of the elbow joint	15
6. Fracture of two bones of the elbow joint (spine and elbow bone)	10
7. Fracture of one bone of the elbow joint	5
8. Dislocation of the elbow joint	3
9. Fracture of one bone of the forearm (except the joint) without dislocation	6
10. Fracture of one bone of forearm with dislocation, double fracture of one bone or fracture of both bones	8
11. Fracture of any bone forearm growth (processes styloideus)	3
12. Traumatic forearm amputation	50
13. Perilunar dislocation of the wrist	6
14. One fracture of the wrist or wrist bone (excluding boat bone)	3
15. Fractures of two or more wrists or wrists, boat-shaped fractures	6
16. Wrist ligament damage	1
17. Damage to the first finger of the hand:	
17.1. nail plate rupture	1
17.2. fracture, dislocation, injury with phalanx soft tissue damage, rupture of tendon capsule	3

No, Bone fracture or injury	Comp. %
18. Damage to finger II, III, IV or V of the hand:	
18.1. nail plate rupture	0.5
18.2. fracture, dislocation, rupture of a tendon or capsule, massive loss of soft tissue	1.5
IV. CHEST, RIBS, PELVIS, THIGH, LOWER LEG, FOOT	
1. Sternal fracture	5
2. Piercing traumatic chest injury:	
2.1. without damage to the organs of the chest	10
2.1. with damage to the organs of the chest	15
3. Rib fracture	1
4. Fracture of one pelvic bone (intestinal bone, sciatic bone, pubic bone)	6
5. Double fracture of one bone of the pelvis, fracture of several bones, rupture of one joint	8
6. Fracture of several pelvic bones with simultaneous damage to the small pelvic organs	16
7. Dislocation of hip bone fragments as a result of injury	3
8. Dislocation of the hip joint	6
9. Hip bone head, neck fracture	20
10. Fracture of the femur at any level except the joint area (30 % in the case of a double fracture)	25
11. Knee hemarthrosis (proven by puncture)	1
12. Knee joint (meniscus damage, bone fragments)	3
13. Knee joint cruciate ligament rupture, knee dislocation (except patella)	4
14. Knee patella, intercostal growth, bone condyle fracture	5
15. Patella dislocation of the knee joint (in case of repeated dislocation 1 %)	3
16. Bone fracture forming a knee joint (distal metaphyses of the thigh, condyle fracture together with a proximal fracture of any bone in the lower leg)	15
17. Fracture of the tibia	5
18. Fracture of large tibia of lower leg (excluding joint areas)	8
19. Fracture of both bones of lower leg, double fracture of fibula (except joint areas)	12
20. Fracture of one ankle of the lower leg (in case of fracture of two ankles 5%)	4
21. Fractures of one bone of the lower leg as the only trauma	4
22. Fracture of two ankles with fracture of the margin of the tibia, intra-articular fracture of the tibia	7
23. Achilles tendon lesion:	
23.1. treating conservatively	4
23.2. treating surgically	7
24. Tension of the ligaments of the foot joint	1
25. Rupture, sprain, damage of the ligaments of the foot joint	3
26. Dislocation of the foot joint (in case of repeated dislocation 2 %)	5
27. Fracture of the base of one foot (excluding the heel bone), fracture of the metatarsal or dislocation of the metatarsal	3
28. Fracture of heel bone, fracture of three or more foot bones, metacarpal foot bone	7
29. Traumatic foot amputation or injury followed by amputation	20–40
30. Fractures of the toes, dislocations, rupture of tendons (if several, the compensation does not exceed 4 %)	2
31. Rupture or stretching of the internal ligaments of the foot	1
V. VISION AND HEARING ORGANS	
1. Paralysis of one eye accommodation	10
2. Injury to the tear ducts of one eye, which has caused a dysfunction	3
3. A foreign body has entered the eye	1
4. Traumatic eye injury:	
4.1. which did not cause a decrease in visual acuity	5
4.2. which caused a decrease in visual acuity not earlier than 2 months after the injury	5–50
5. Damage to the cochlea	5–15
6. Hearing loss after traumatic ear injury (not earlier than 2 months after the injury):	
6.1. Rupture of one eardrum due to injury (without hearing loss)	3 –5
6.2. Rupture of one eardrum due to injury (with hearing loss)	10–15
VI. INTERNAL ORGAN SYSTEMS	
1. Damage to the heart and major blood vessels without functional disorders	20
2. Damage to large peripheral blood vessels, resulting in heart and circulatory failure	20
3. Damage to large peripheral blood vessels without circulatory disorders	10
4. Lung damage: hemothorax, pneumothorax	5
5. Traumatic injury, rupture of the throat, esophagus, intestinal tract	5
6. Traumatic damage to the tongue resulting in partial loss of the tongue (depending on the level)	5–45
7. Traumatic, puncture damage of the stomach, intestines, pancreas:	
7.1. followed by suturing, necrosis	15
7.2. partial or complete surgery of the stomach, intestines, pancreas	20–30
8. Bruising or contusion of the thoracic and abdominal organs	3

No, Bone fracture or injury	Comp. %
9. Traumatic hernia of the anterior abdominal wall or diaphragm, excluding hernias resulting from weight lifting	5
10. Traumatic hernia of the anterior abdominal wall or diaphragm due to weight lifting	1
11. Traumatic liver damage, liver rupture, without surgery	10
12. Traumatic liver injury, liver rupture, resulting in surgery	25
13. Traumatic damage to the gallbladder as a result of surgery	15
14. Traumatic rupture of the spleen:	
14.1. without surgical intervention	5
14.2. spleen surgery	15
15. Traumatic kidney damage:	
15.1. bruise, rupture without surgery	5
15.2. with partial or complete renal surgery	10–30
16. Traumatic damage of ureters, bladder, urinary tract	3–10
17. Traumatic damage to the genitals caused by	
17.1. partial loss of one ovary, fallopian tube, one testicle, full penis	15
17.2. partial loss of both ovaries, both fallopian tubes, both testicles, uterus, penis	40
17.3. genital lesions in women (without organ loss) (ovaries, fallopian tubes, uterus, vaginal external genitalia) without surgery	5
17.4. genital lesions in women (without organ loss) (ovaries, fallopian tubes, uterus, vaginal external genitalia) with surgery	20
18. Traumatic injury of the larynx and trachea	10

No, Bone fracture or injury	Comp. %
VII. SOFT TISSUE DAMAGE AND OTHER INJURY	
1. Traumatic lesions of the soft tissues of the face, neck, pelvis, which have caused a permanent cosmetic defect (at least 2 sutures applied)	1–40
2. Traumatic damage to the soft tissues of the body, limbs, scalp, which has caused the formation of a scar (wound from 2 cm), except for postoperative and open bone fracture scars	1–15
3. Traumatic shock, traumatic haemorrhagic shock, anaphylactic shock	5
4. Muscle rupture	2
5. Acute poisoning leading to toxic hepatitis	5
6. Accidental acute poisoning	3
7. Minor injuries (bruises, abrasions, hematomas, as a result of which the doctor has issued an exemption from the study visit for at least 5 days)	0.5