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Gjensidige

Accident Insurance Terms and Conditions No 6.5

Valid as of February 3, 2020

1. Terms and Definitions

*Terms used in these Terms and Conditions but not explicitly defined herein, shall bear the same meaning as defined in the General Insurance Terms and Conditions of ADB "Gjensidige" Latvian branch.

1.1. **Insurable Object** – life, health or physical condition of the Insured, as well as other unexpected losses or costs specified in the Policy incurred by the Insured as a result of an Accident.

1.2. **Accident** – harm caused to the Insured person's health or life (trauma, irreversible disability or death) and/or financial losses as a result of external factors beyond the Insured person's control.

1.3. **Insurance Indemnity Calculation Tables** – one or several tables enclosed as Appendix to these Terms and Conditions: Table A, Table B, Table C, Table D, Table F, Table G or Table ID, which shall be used to determine the amount of an Insurance Indemnity.

1.4. **Insurance Period** – the term specified in the Insurance Contract that does not exceed 365 consecutive calendar days. The Parties shall determine the term of validity based on the time zone of the Republic of Latvia.

1.5. **Waiting Period** – unless otherwise specified in the Insurance Contract, the Waiting Period shall be 90 (ninety) days from the first day of the Period of the Insurance Contract (Insurance period) concluded in favour of the Insured. If during the Period of Validity of the Insurance Contract it is supplemented with a new Insured, the Waiting Period for this person shall be calculated from the date when this person was included in the list of the insured persons. The Waiting Period shall not be calculated for the subsequent Insurance Contracts if immediately after expiry of the Insurance Contract containing the risk "Critical Illnesses" a new Insurance Contract containing the risk "Critical Illnesses" is concluded in favour of the Insured and between these two consecutively concluded Insurance Contracts there has been no interruption and no changes are made to the Terms and Conditions of the Insurance Contract.

1.6. **Survival Period** – unless otherwise specified in the Insurance Contract, the Survival Period shall be 28 (twenty-eight) days from the Start Date of an Illness.

1.7. **Initial Diagnosis of an Illness** – a temporary diagnosis of an Illness that is written in the medical documentation of the Insured, based on the symptoms characteristic to the Illness and the anamnesis data thereof.

1.8. **Final Approved Diagnosis of an Illness** – a diagnosis of an Illness that is proven with corresponding laboratory and instrumental medical tests and approved by an opinion of the respective medical specialist and written in the medical documentation of the Insured.

1.9. **Start Date of an Illness** – the date when the Final Approved Diagnosis of an Illness is established. The date when the Initial Diagnosis of an Illness is registered shall be also regarded as the Start Date of an Illness provided that no later than within 1 (one) month after expiry of the Insurance Contract, the Initial Diagnosis of an Illness is confirmed as the Final Approved Diagnosis of an Illness by the opinion of the respective medical specialist.

1.10. **Injury** – a damage of tissue and organs (body) caused by an external factor (mechanical, chemical, thermal etc.) causing functional disorder thereof and indicated in the Insurance Indemnity Calculation Table.

1.11. **Bone Fracture of an Increased Risk** – a bone fracture that has occurred as a result of an impact of an external force on the background of a changed bone structure and/or damaged joints (stretched tendons, sprained joint, capsular disruption).

1.12. **Pathologic Fracture** – a bone fracture caused by a prior disease or occurred without an impact of external factors.

1.13. **Profession Insurance** – insurance of the employees of legal entities, taking into consideration the number of employees. If the number of employees has not changed for more than 10% within the insurance period, the insurance coverage is valid also for new employees.

1.14. **Additional Risks** – activity that does not include daily physical or sports activities, which the Insured performs individually or by an organized participation in a team with an aim to maintain or improve physical capabilities and skills, including driving a motor vehicle (quad bike, motorbike or scooter with the engine capacity below 125 cm3). The following additional risks may be insured if they are specified in the Insurance Contract:

1.14.1. **Hobby of an Increased Risk** – a physical activity which requires physical fitness, regular training, certain equipment and/or outfit and during which there is a risk that the life, health or physical condition of the Insured can be endangered.

1.14.2. **Sports Activities of an Increased Risk** – high risk activities, for example, driving a motor vehicle (with the engine capacity of above 125 cm3), rock climbing, cave diving, diving deeper than 10 m, kiteboarding, kitesurfing, rafting, parachuting from fixed objects, wingsuit flying etc., during which the Insured is exposed to a high risk of getting injuries or traumas.

1.14.3. **Children/youth sports** – physical activity for the Insured below 18 years of age, carried out specially, individually or in groups, during trainings or competitions.

1.14.4. **Amateur Sports** – types of physical activities carried out by the Insured individually or as an organized participation in a team and aimed at maintenance or improvement of physical capabilities and skills and/or participation in competitions.

1.14.5. **Professional Sports** – a professional sportsman is a private individual, who based on employment contract and for the agreed payment is preparing for sports competitions and participating in them.

2. Apdrošinātais risks

2.1. Risks listed in these Terms and Conditions shall be insured only if they are specified and noted in the Policy.

2.2. In accordance with these Terms and Conditions the following risks can be insured:

2.2.1. Death.

2.2.2. Disability:

2.2.2.1. according to the nature of injuries and amount of Insurance Indemnity specified in Table A;

2.2.2.2. according to the nature of injuries and amount of Insurance Indemnity specified in Table B;

2.2.2.3. according to the nature of injuries and amount of Insurance Indemnity specified in Table C.

2.2.3. Trauma:

2.2.3.1. according to the nature of injuries and amount of Insurance Indemnity specified in Table D;

2.2.3.2. according to the nature of injuries and amount of Insurance Indemnity specified in Table E;

2.2.3.3. fractures according to the nature of injuries and amount of Insurance Indemnity specified in Table F;

2.2.3.4. burns and frostbites according to the nature of injuries and amount of Insurance Indemnity specified in Table G.

2.2.4. Daily Allowance.

2.2.5. Hospital Allowance.

2.2.6. Medical Expenses.

2.2.7. Cosmetology Expenses.

2.2.8. Rehabilitation Expenses.

2.2.9. Critical Illnesses.

2.2.10. Death as a result of a critical illness or elective surgery.

2.2.11. Infectious Diseases.

2.3. **The Risk "Death"**

2.3.1. The risk "Death" is harm caused to the Insured person's health as a result of an Accident that has caused death of the Insured.

2.3.2. The Insurer shall pay an Insurance Indemnity to the Beneficiary if as a result of an Accident that has happened during the Insurance Period, the Insured dies within 1 calendar year from the Accident.

2.3.3. Insurance Indemnity shall be paid in the amount of the Sum Insured as specified in the Policy, deducting the sum of all the Insurance Indemnities paid under this Insurance Contract.
2.3.4. Insurance Indemnity shall be paid to legal heirs of the Insured according to the procedure stipulated in the laws and regulations of the Republic of Latvia unless otherwise specified in the Insurance Contract.

2.4. **The Risk "Disability"**
2.4.1. The risk "Disability" is harm caused to the Insured person's health as a result of an Accident that has caused irreversible disability of the Insured.
2.4.2. The Insurer shall pay an Insurance Indemnity for the risk "Disability" if it is acquired as a result of an Accident that has happened during the Insurance Period and if the State Medical Commission for the Assessment of Health Condition and Working Ability has granted a disability status no later than within one calendar year from the Accident.
2.4.3. The Insurer shall calculate the Insurance Indemnity for the risk "Disability" according to the Insurance Indemnity Calculation Table(s) (Table A, Table B, Table C) specified in the Policy.
2.4.4. If due to an injury suffered by the Insured a disability category is granted, the Insurer shall pay an Insurance Indemnity according to Table A, and payment of indemnities for injuries according to Table B or Table C shall not be made.
2.4.5. If several injuries resulting from the same Accident are established, the Insurer shall pay an Insurance Indemnity only for one injury that is the most severe as per the Insurance Indemnity Calculation Table (Table A, Table B, Table C).

2.5. **The Risk "Trauma"**
2.5.1. The risk "Trauma" is harm caused to the Insured person's health as a result of an Accident that has happened during the Insurance Period and has been medically confirmed immediately after the Accident but no later than within 48 hours from the day of the Accident.
2.5.2. The Insurer shall calculate the Insurance Indemnity for the risk "Trauma" according to the Insurance Indemnity Calculation Table(s) (Table D, Table E, Table F, Table G) specified in the Policy.
2.5.3. If several injuries resulting from the same Accident are established, the Insurer shall pay an Insurance Indemnity for all injuries listed in the Insurance Indemnity Calculation Tables (Table D, Table E, Table F or Table G).
2.5.4. If a Bone Fracture of an Increased Risk is established, an Insurance Indemnity shall be paid in the amount of 50% of the Insurance Indemnity specified in the Insurance Indemnity Calculation Tables (Table D, Table E, Table F or Table G).
2.5.5. If the Insurance Indemnity for a trauma has already been paid according to any of the Insurance Indemnity Calculation Tables (Table D, Table E, Table F or Table G) but direct and more severe consequences are established within six months from the day of occurrence of the Accident corresponding to an injury specified in the Insurance Indemnity Calculation Tables (Table D, Table E, Table F or Table G), upon paying Insurance Indemnity for such related consequences, the amount of initially paid Insurance Indemnity for the trauma shall be deducted thereof.
2.5.6. When paying an Insurance Indemnity for the risk "Trauma", amounts of the Insurance Indemnity paid out previously for the risk "Critical Illnesses" under the concluded Insurance Contract shall be deducted thereof, if, as a result of the trauma, a critical illness stated in Clause 2.1.12 has been diagnosed and confirmed.
2.5.7. Insurance Indemnity shall not be paid for a burn of the degree 1 and frostbite of the degree 1.

2.6. **The Risk "Daily Allowance"**
2.6.1. The risk "Daily Allowance" occurs if, as a result of an Accident that has happened during the Insurance Period, the Insured temporary becomes incapable for work for a time period exceeding 7 (seven) working days.
2.6.2. The Insurer shall calculate and pay the Insurance Indemnity for the risk "Daily Allowance" according to the information provided in the certificate of incapacity for work.
2.6.3. The Insurer shall pay the Insurance Indemnity for the risk "Daily Allowance" for each day of incapacity for work in the amount specified in the Policy but for no more than 60 (sixty) days of incapacity per Insurable Event and for no more than 180 (one hundred and eighty) days of incapacity throughout the entire Insurance Period. Only working days shall be considered as days of incapacity for work.
2.6.4. Insurance Indemnity for the risk "Daily Allowance" shall be paid exclusively for the days of incapacity for work within the Insurance Period.
2.6.5. Insurance Indemnity for the risk "Daily Allowance" shall not be paid:
2.6.5.1. for the days of incapacity for work that have already been covered under the risk "Hospital Allowance";
2.6.5.2. if incapacity for work is caused by congenital, chronic or occupational diseases, or when suffering from infectious diseases, unless the disease is listed in the Insurance Indemnity Calculation Table enclosed to the Insurance contract;
2.6.5.3. if in case of a temporary incapacity for which a certificate of incapacity for work has been issued, the Insured has been at work and carried out his/her direct duties or similar/substitute duties.
2.6.6. Payment of the Insurance Indemnity for the risk "Daily Allowance" shall be discontinued as of the day when the decision on granting a disability status is made.

2.7. **The Risk "Hospital Allowance"**
2.7.1. The risk "Hospital Allowance" occurs if as a result of an Accident that has happened during the Insurance Period, the Insured is taken to a hospital and stays there as a patient for at least 48 hours.
2.7.2. The Insurer shall pay an Insurance Indemnity for the risk "Hospital Allowance" for each twenty-four hours spent at an inpatient care hospital in the Republic of Latvia in the amount specified in the Policy but for no more than 60 (sixty) days per Insurable Event and for no more than 180 (one hundred and eighty) days throughout the entire Insurance Period.
2.7.3. Insurance Indemnity for the risk "Hospital Allowance" shall be paid exclusively for the days and nights spent at an inpatient care hospital in the Republic of Latvia within the Insurance Period.
2.7.4. The Insurance Indemnity for the risk "Hospital Allowance" shall not be paid for outpatient treatment at a day hospital, rehabilitation institutions or staying at a care division of a hospital.

2.8. **The Risk "Medical Expenses"**
2.8.1. The risk "Medical Expenses" occurs if, as a result of an Accident that has happened during the Insurance Period, the treatment of traumas or fractures incurred by the Insured takes place at a medical institution registered in the territory of the Republic of Latvia.
2.8.2. During the Insurance Period and without exceeding the Sum Insured as determined for the respective risk in the Policy, the Insurer shall pay an Insurance Indemnity for the risk "Medical Expenses" exclusively for:
2.8.2.1. patient contribution;
2.8.2.2. outpatient and inpatient medical services prescribed by the attending physician;
2.8.2.3. medication registered in the Drug Register of the Republic of Latvia and prescribed by the attending physician;
2.8.2.4. purchase of bandages prescribed by the attending physician;
2.8.2.5. purchase or rent of medical aids prescribed by the attending physician and necessary for treatment of physical traumas;
2.8.2.6. transfer to a medical institution with medical transportation.
2.8.2.7. Indemnity for surgeries performed as a result of trauma is paid within the limit, but no more than 500 EUR (five hundred EUR) per case.

2.9. **The risk "Cosmetology Expenses"**

2.9.1. The risk "Cosmetology Expenses" occurs if, as a result of an Accident that has happened during the Insurance Period, the necessary plastic surgery treatment of traumas or fractures incurred by the Insured takes place at a medical institution registered in the territory of the Republic of Latvia.

2.9.2. During the Insurance Period and without exceeding the Sum Insured as determined for the respective risk in the Policy, the Insurer shall pay an Insurance Indemnity for the risk "Cosmetology Expenses" exclusively for:

2.9.2.1. cosmetic surgeries that are carried out to eliminate permanent physical and mutilating external defects of the body after burns resulting from an Accident;

2.9.2.2. cosmetic surgeries to eliminate mutilating skin damages in the area of head and neck;

dental services (implantation and prosthetics of teeth) in relation to loss or damage of teeth.

2.10. **The Risk "Rehabilitation Expenses"**

2.10.1. The risk "Rehabilitation Expenses" occurs if, as a result of an Accident that has happened during the Insurance Period, the treatment of traumas or fractures incurred by the Insured takes place at a medical institution registered in the territory of the Republic of Latvia based on a referral of a medical specialist.

2.10.2. During the Insurance Period and without exceeding the Sum Insured as determined for the respective risk in the Policy, the Insurer shall pay an Insurance Indemnity for the risk "Rehabilitation Expenses" exclusively for:

2.10.2.1. 10 physiotherapy procedures prescribed by the attending physician;

2.10.2.2. up to 10 procedures of medical massage, water therapy (including underwater massages, mud procedures), medical gymnastics, manual therapy prescribed by the attending physician for treatment of consequences of an Accident.

2.11. **The Risk "Daily Allowance"**

2.11.1. The risk "Daily Allowance" occurs if, as a result of an Accident that has happened during the Insurance Period, the Insured temporary becomes incapable for work for a time period exceeding 7 (seven) working days.

2.11.2. The Insurer shall calculate and pay the Insurance Indemnity for the risk "Daily Allowance" according to the information provided in the certificate of incapacity for work.

2.11.3. The Insurance Indemnity for the Insured Risk "Daily Allowance" shall be paid for each day of incapacity for work in the amount specified in the Policy but for no more than 60 (sixty) days of incapacity per Insurable Event and for no more than 180 (one hundred and eighty) days of incapacity throughout the entire Insurance Period.

2.11.4. The Insurance Indemnity for the Insured Risk "Daily Allowance" shall be paid for no more than 10 days of incapacity per Insurance Period if the Insured at the moment of the Accident has not earned any income or has not been in a remunerative work.

2.11.5. Insurance Indemnity for the risk "Daily Allowance" shall be paid exclusively for the days of incapacity for work within the Insurance Period.

2.11.6. Payment of an Insurance Indemnity for the Insured Risk "Daily Allowance" shall start from the 11th day of incapacity for work if the Insured as a result of an Accident has got injuries for which the indicated amount of Insurance Indemnity specified in the Insurance Indemnity Calculation Table (Table A, Table B or Table C, Table D, Table E, Table F or Table G) exceeds 2 (two) percent.

2.11.7. Insurance Indemnity for the risk "Daily Allowance" shall not be paid:

2.11.7.1. for the days of incapacity for work that have already been covered under the risk "Hospital Allowance";

2.11.7.2. if in case of a temporary incapacity for work for which a certificate of incapacity for work has been issued, the Insured has been at work and carried out his/her direct duties or similar/substitute duties.

2.11.8. Payment of the Insurance Indemnity for the risk "Daily Allowance" shall be discontinued as of the day when the decision on granting a disability status is made.

2.11.9. Insurance Indemnity for the risk "Daily Allowance" that has occurred simultaneously with the risk "Trauma" cannot exceed the amount payable as Insurance Indemnity for the "Trauma" risk.

2.11.10. The Insurer shall pay an Insurance Indemnity for the risk "Daily Allowance" to the legal representative of the Insured person if a temporary incapacity for work is necessary for caring for an ill child (of the Insured person).

2.12. **The Risk "Critical Illnesses"**

2.12.1. The risk "Critical Illnesses" occurs if during the Insurance Period the Insured has been diagnosed with and confirmed of having any of the below stated Critical Illnesses (hereinafter – a Critical Illness), provided that the Critical Illness has not occurred due to a decompensation and/or as a result of complications of another illness and it has not been indicated as a comorbid diagnosis:

2.12.1.1. **Myocardial Infarction**

2.12.1.1.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, myocardial infarction, if the diagnosis is confirmed by a cardiologist and clinically and diagnostically proved with all of the below listed diagnostic criteria of myocardial infarction:

a. a clinical profile typical to myocardial infarction;
b. new electrocardiographic changes that are typical to myocardial infarction;
c. increase of ferments, troponines and other biochemical markers specific to myocardial infarction.

2.12.1.1.2. The following shall not be deemed as Insurable Events:

a. a non-ST segment elevation myocardial infarction (NSTEMI) only with the increase of Troponine I or T;
b. a silent infarction;
c. a myocardial infarction as a result of accidents;
d. other acute coronary syndromes and symptoms;
e. a case when an acute myocardial infarction is suspected but the Insured refuses in writing from hospitalization.

2.12.1.2. **Stroke**

2.12.1.2.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, stroke, if the diagnosis is confirmed by a neurologist or neurosurgeon and clinically and diagnostically proved with all of the below listed criteria of stroke:

a. clinical symptoms that correspond to the diagnosis;
b. typical evidence by the computer tomographic scanning or magnetic resonance, indicating to a new stroke;
c. proof of the existence of permanent neurologic damage and neurologic deficit for a time period of at least 3 (three) months from the applied therapy.

2.12.1.2.2. The following shall not be deemed as Insurable Events:

a. temporary cerebral hemodynamic disturbances;
b. traumatic cerebral damages;
c. neurologic symptoms due to migraine;
d. lacunar stroke without a neurologic deficit.

2.12.1.3. **Paralysis**

2.12.1.3.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, paralysis, if the diagnosis is confirmed by a neurologist or neurosurgeon and remains unchanged for a time period of 6 (six) months from the said approval or the course of the illness is progressive which is confirmed by an opinion of a neurologist or neurosurgeon.

2.12.1.3.2. The following shall not be deemed as Insurable Events:

a. flaccid or spastic paraplegia;
b. paralysis in case of the Guillain-Barre syndrome.

2.12.1.4. **Cancer**

2.12.1.4.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, cancer, if the diagnosis is based on the results of histologic examination confirmed by an oncologist or pathologist. A diagnosis shall be deemed as the Final Approved Diagnosis on the date when the results of histologic examination are obtained.

2.12.1.4.2. The following shall not be deemed as Insurable Events:

a. any stage of CIN;
b. any pre-cancer stage;
c. stage 1 of any cancer;
d. cancer in-situ;
e. papillary thyroid carcinoma (PTC);
f. lymphoma (Hodgkin's and non-Hodgkin's);
g. intraocular cancer;
h. all skin cancers;
i. any cancer associated with an immunodeficiency syndrome.

2.12.1.5. **Chronic Renal Failure**

2.12.1.5.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, chronic renal failure, if the diagnosis is confirmed by a nephrologist and clinically and diagnostically proved, and regular peritoneal hemodialysis or renal transplantation is necessary for the treatment thereof.

2.12.1.5.2. Chronic renal failure that has occurred as a result of intoxication of alcohol, narcotic or other toxic substances shall not be considered an Insurable Event.

2.12.1.6. **Multiple or Disseminated Sclerosis**

2.12.1.6.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, multiple or disseminated sclerosis, if the diagnosis is confirmed by a neurologist or another medical specialist and clinically and diagnostically proved with all of the below listed criteria of multiple or disseminated sclerosis:

a. clinical symptoms that correspond to the diagnosis;
b. typical evidence of cerebral lesions that are proved by the computer tomographic scanning or magnetic resonance;
c. proof of the existence of a continuous neurologic pathology and neurologic deficit for a time period of at least 6 (six) months from the applied therapy.

2.12.1.6.2. No other illness with similar criteria shall be deemed as an Insurable Event.

2.12.1.7. **HIV**

2.12.1.7.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, HIV if the final approved diagnosis has been confirmed by the medical documentation containing an infectious disease specialist’s opinion. Insurance Indemnity is paid only if HIV is diagnosed for the first time during the period of validity of the Insurance Contract and the Insured has submitted documents (patient records statement, court decision and other documents) confirming that HIV has been acquired through blood transfusion in the particular medical institution.

2.12.1.7.2. Any other cause of HIV infection (including unknown cause) shall not be deemed as an Insurable Event.

2.12.1.8. **Lyme Borreliosis**

2.12.1.8.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, Lyme borreliosis if a tick bite is diagnosed during the period of validity of the Insurance Contract, a tick has been removed in a medical institution, the illness has been approved by lab tests and the Lyme disease has caused permanent brain damage, i.e. neuroborreliosis, confirmed by a neurologist’s or any other medical specialist's opinion and documented dynamic development of the disease over the period of at least three months.

2.12.1.8.2. Any other clinical manifestation of Lyme disease shall not be deemed as an Insurable Event.

2.12.1.9. **Organ Transplantation**

2.12.1.9.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, “Organ transplantation” if due to permanent damage of the respective organ and sustained unsuccessful replacement therapy the Insured needs a heart, heart and lungs, liver, kidney, pancreas or bone marrow transplant operation. The diagnosis must be confirmed by the respective medical specialist and proved both, clinically and diagnostically. Transplantation must be medically necessary and the organ damage must be diagnostically confirmed. Likewise, inclusion of the Insured on the official waiting list for transplantation of the above mentioned organ shall be also deemed as an Insurable Event.

2.12.1.9.2. Ensuring functionality of the organ by means of replacement therapy shall not be deemed as an Insurable Event.

2.12.1.10. **Loss of Vision**

2.12.1.10.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, “Loss of vision” if the Insured is diagnosed with permanent loss of vision in both eyes.

2.12.1.10.2. Anticipated loss of vision or diminished vision shall not be deemed as an Insurable Event.

2.12.1.11. **Loss of One or more Limbs**

2.12.1.11.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, “Loss of one or more limbs” if the Insured has lost one or more limbs, or complete and permanent paralysis above the knee and elbow joint. Paralysis must be lasting for consecutive six months and the diagnosis must be confirmed by the respective medical specialist.

2.12.1.11.2. The following shall not be deemed as Insurable Events:

a. flaccid or spastic paraplegia/hemiplegia;
b. temporary neurological disorders;
c. surgical amputation due to complications associated with illness.

2.12.1.12. **Heart Surgery**

2.12.1.12.1. The Insurer shall calculate and pay an Insurance Indemnity specified in the Policy for the Critical Illness, namely, “Heart surgery” if the Insured is subject to replacement of one or more contracted or completely blocked coronary arteries by means of shunting, which may be deemed as an Insurable Event. The coronary artery blockage must be diagnostically justified (coronary angiography) and the surgical operation must be cardiologically indicated.

2.12.1.12.2. Percutaneous transluminal coronary angioplasty and other invasive manipulations shall not be deemed as an Insurable Event.

2.12.2. In case of occurrence of the risk “Critical Illnesses” the Insurer shall after expiry of the Survival Period calculate and pay one-off Insurance Indemnity to the extent specified in the Policy.

2.12.3. When paying Insurance Indemnity for the risk “Critical Illnesses”, amounts of the Insurance Indemnity paid out previously for the risk “Trauma” under the concluded Insurance Contract shall be deducted thereof, if trauma stated in Clause 2.5 has been caused as a result of a Critical Illness.

2.12.4. Once Insurance Indemnity for the risk “Critical Illnesses” is paid, the Insurance Contract with regard to the risk “Critical Illnesses” shall be terminated for the particular Insured.

2.12.5. If during the Insurance Period an Initial Diagnosis of a Critical Illness is registered, which after expiry of the Insurance Period but no later than within 1 (one) month following the date of registration of the Initial Diagnosis of a Critical Illness, is confirmed as the Final Approved Diagnosis of an Illness by the medical documentation containing an opinion of the respective medical specialist, it shall be deemed that Insurable Event has occurred.

2.12.6. If after expiry of the Survival Period the Insured dies as a result of a Critical Illness, the Insurer shall pay Insurance Indemnity, provided that the Final Approved Diagnosis of an Illness was established while the Insured was alive.
2.12.7. Insurance indemnity for this risk "Critical Illnesses" shall not be paid if:
2.12.7.1. the Critical Illness as an Initial Diagnosis has been diagnosed before conclusion of the particular Insurance Contract or during the Waiting Period;
2.12.7.2. during the Waiting Period, the Final Approved Diagnosis of an Illness is established for the the Insured or the Insured dies as a result of illness;
2.12.7.3. during the Survival Period, the Insured dies as a result of the Critical Illness;
2.12.7.4. the Critical Illness has developed as a result of a long-term, chronic process or continuous illness;
2.12.7.5. the Insured has disregarded instructions given by a medical specialist, which should be observed for ensuring successful treatment of illness.

2.13. **Risk "Death as a Result of a Critical Illness or Elective Surgery"**
2.13.1. The risk "Death as a result of a critical illness or elective surgery" occurs if during the Insurance Period the Insured has been first time diagnosed with and confirmed of having any of the below stated Critical Illnesses, as well as if death occurs during the elective surgery or within 24 (twenty four) hours after such surgery:
2.13.1.1. Meningococcal disease – sudden death caused by Meningococcal disease;
2.13.1.2. Stroke, apoplexy – sudden death, caused by cerebrovascular disorder, but which are not related to brain damage as a result of an accident and the Insured has not reached the age of 55 (fifty five);
2.13.1.3. Miocardial infarction – sudden death in relation to irreversible damage of heart muscles, if the Insured has not reached the age of 55 (fifty five);
2.13.1.4. Ebola virus - sudden death directly caused by Ebola virus;
2.13.1.5. Death as a result of elective surgery - sudden death during the elective surgery, caused by the surgery, which is not related to a Chronic disease;
2.13.2. In case of occurrence of the risk "Death as a result of a critic Illness or elective surgery" the Insurer shall calculate and pay one-off Insurance Indemnity to the extent specified in the Policy.
2.13.3. The Insurance indemnity for the Risk "Death as a result of a critical illness or elective surgery" is not paid, if:
2.13.3.1. the Critical Illness as an Initial Diagnosis has been diagnosed before conclusion of the particular Insurance Contract or during the Waiting Period;
2.13.3.2. the elective surgery was planned before the conclusion of the Insurance Contract or during the Waiting Period;
2.13.3.3. Death of the Insured which has occurred during the Waiting Period;
2.13.3.4. the Insured has disregarded instructions given by a medical specialist, which should be observed for ensuring successful treatment of illness.

2.14. **The Risk "Infectious Diseases"**
2.14.1. The risk "Infectious Diseases" occurs if during the Insurance Period, the Insured is first time diagnosed with and confirmed of having any of the diseases listed in the Indemnity calculation Table ID.
2.14.2. The waiting period for the risk "Infectious diseases" shall be 30 (thirty) days from start date of the Insurance period.
2.14.3. The indemnity for the risk "Infectious Diseases" shall be paid to the extent specified in the Indemnity calculation Table ID.
2.14.4. The indemnity for the risk "Infectious Diseases" shall be paid if the illness is treated in an in-patient institution at least 2 (two) days.

3. Insurable Event

3.1. An incident shall be deemed as an Insurable Event if such has occurred during the period of validity of the Insurance Contract and its consequences have manifested no later than within six months after expiry of the respective Insurance Contract.
3.2. Insurable Event as a result of which payout of the Insurance Indemnity is provided for, shall be deemed events caused by:
3.2.1. traumas with subsequent disorders of anatomical wholeness of tissues and physiologic dysfunctions;
3.2.2. herb or chemical poisoning except foodborne intoxications, alcohol or other substance intoxication and usage of narcotic drugs without a doctor's prescription;
3.2.3. burns, frostbites, lightning or current impact;
3.2.4. weapon related injuries if such effect is not connected with illegal activity by the Insured;
3.2.5. accidental ingestion of foreign bodies in respiratory or gastrointestinal tract (for the risk of "Death");
3.2.6. drowning (for the risk of "Death");
3.2.7. anaphylactic shock (for the risk of "Death");
3.2.8. overcooling of body (for the risk of "Death");
3.2.9. tick-borne encephalitis, Lyme disease;
3.2.10. other insurable events listed in the special terms and conditions.

4. Exceptions

4.1. Incidents shall not be deemed as Insurable Events if they are caused by:
4.1.1. the Insured being under the influence of alcohol, drugs or psychotropic substances;
4.1.2. mental disorders, loss of memory, epilepsy or other cramp attacks, stroke, cerebral contusion, cardiac infarction, diabetes mellitus or other illnesses;
4.1.3. a suicide or an attempt to commit a suicide;
4.1.4. a nuclear accident, nuclear or other explosion and/or radioactive irradiation;
4.1.5. war (both, declared and undeclared), revolutions, mass riots, sabotage, and terror acts;
4.1.6. disability, the existence of which was concealed while concluding the Insurance Contract;
4.1.7. an epidemic, pandemic;
4.1.8. Engagement of the Insured in Hobby of an Increased Risk, Sports of an Increased risk, Children, Youth sports, Amateur sports, Professional sports, if it is not specified in the Contract;
4.1.9. performing of any action if such action is related to an increased risk of accidents, whereof the Insurer has not been duly informed;
4.1.10. disregard of a doctor's recommendations and/or instructions related to work, rest and treatment;
4.1.11. tick-borne encephalitis if no preventive vaccination was done within the required timeframe and according to the set procedure;
4.1.12. alternative treatment methods;
4.1.13. health damage due to which the Insured is considered to be disabled;
4.1.14. insect bites;
4.1.15. abdominal and lower abdominal wall hernia caused as a result of lifting heavy objects;
4.1.16. intervertebral disk damages;
4.1.17. pathologic fractures;
4.1.18. recurrent bone fractures if they have occurred while the previous fracture has not been healed yet.
4.2. Incidents shall not be deemed as Insurable Events if they had happened while the Insured:
4.2.1. was taking an illegal action regardless of his/her mental, psychic or other health condition;
4.2.2. is lawfully arrested or is in custody;
4.2.3. has failed to comply with the statutory regulations or rules, road traffic regulations etc. which are in force in the territory covered by the Contract, including, driving a car without the driver's licence of a relevant category.

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4.3. Incidents shall not be deemed as Insurable Events if the Insured:
4.3.1. was driving or was a passenger on a motorbike with engine power above 60 kW, or a motor scooter;
4.3.2. was flying with any aircraft except as a passenger in an airplane that belongs to an airline company and is registered as a passenger transportation vehicle for a definite route;
4.3.3. was sailing except as a passenger in a ship that is registered as a passenger transportation vehicle for a definite route;
4.3.4. was participating in trainings, competitions or test drives with road motor vehicles, watercrafts or aircrafts in the capacity of a driver/ pilot or a passenger;
4.3.5. was serving in the armed forces (including combatant service in the Home Guard);
4.3.6. was participating in military operations or trainings.
4.4. Insurance shall not cover expenses for:
4.4.1. medical costs outside the Republic of Latvia;
4.4.2. luxury service in medical institutions;
4.4.3. alternative treatment methods and diagnostics;
4.4.4. repeated surgical operations;
4.4.5. services provided by a psychotherapist, psychiatrist or psychologist;
4.4.6. treatment that is not related with the Accident;
4.4.7. cosmetic treatment;
4.4.8. sports medicine services;
4.4.9. fees for free choice of physicians, or physicians' fees;
4.4.10. fees for computed tomography and magnetic resonance;
4.4.11. purchase of glasses, contact lenses and hearing aids;
4.4.12. an Accident caused by any kind of radiation unless it is specified in the special terms and conditions of the Insurance Contract;
4.4.13. pathologic fractures;
4.4.14. losses indemnified according to other types of insurance.

5. Conduct of the Parties upon Occurrence of an Insurable Event

5.1. After occurrence of an Insurable Event, the Insured shall take all possible measures to get proper emergency and certified medical assistance as soon as possible, and shall visit a doctor within 24 hours to get medical assistance and follow the doctor's instructions.
5.2. The Policyholder, the Insured or his/her legal representative shall immediately at the first opportunity submit to the Insurer in person the following documents regarding any Insurable Event but no later than within 30 (thirty) days after occurrence of the Insurable Event:
5.2.1. an insurance claim specifying also whether the Insured has any other valid insurance contracts;
5.2.2. documents confirming the fact of an Insurable Event (statements from a medical institution, results of diagnostic examinations, lab tests or radiological examination, x-ray images or electronic copies if required, a copy of death certificate, a statement of an occupational accident etc.);
5.2.3. the Insurer shall be entitled to request originals of all documents listed above.
5.3. The Insurer shall have the right to carry out medical examination of the Insured at its own expense by involving the necessary experts with a purpose to determine the harm caused to health of the Insured as a result of occurrence of an Insurable Event. If the Insured Person (his/her representative) disagrees with the conclusions of the experts engaged by the Insurer, he/she shall be entitled to engage independent experts at his/her own expense.

6. Procedure of Receiving Insurance Indemnity

6.1. 6.1. Insurance Indemnity shall be paid according to the Insured Risk and the Insurer's Insurance Indemnity Calculation Table within 30 days following receipt of all documents required for decision making.
6.2. If, as a result of an Accident, the Insured has suffered several bodily injuries, the Insurance Indemnity shall be paid in accordance with the Insurance Indemnity Calculation Table for the insured risk and these Terms and Conditions.
6.3. If the Insurer has paid the Insurance Indemnity, but as a result of direct consequences of an Accident more serious consequences arise within six month from the day of the Accident, which correspond to the Insured Risk and Insurance Indemnity Calculation Table as a more severe injury for which a higher Insurance Indemnity is envisaged, the Insurer shall reconsider the insurance claim based on a supplementary application.
6.4. When paying a higher Insurance Indemnity according to Clause 6.3 of these Terms and Conditions, the Insurer shall deduct the previous amounts of the Insurance Indemnity paid.
6.5. Upon occurrence of an Insurable Event, the Insurer shall have the right to refuse the Insurance
Indemnity if the Insured, the Beneficiary or the Policyholder has provided incomplete or false information about the Insurable Event or its circumstances, or has failed to submit the required documents and a written insurance claim within 30 days.
6.6. The Insurer may refuse the Insurance Indemnity payment if the Insured has failed to fulfil any of the obligations provided under the Insurance Contract as a result of malicious intent or gross negligence. The Insurer may reduce the Insurance Indemnity payment if the Insured has failed to fulfil any of the obligations provided under the Insurance Contract through negligence.
6.7. If the harm caused to health as a result of an Accident has been affected by previous illnesses or physical disorders of the Insured, the Insurer may reduce the Insurance Indemnity.
6.8. The Insured has been informed and agrees that the Insurer has the right to request and receive information required for fulfilment of obligations under the Insurance Contract from medical specialists who have examined or provided treatment to the Insured, from other insurers, public and local authorities, or medical institutions.
6.9. The Insurer shall not pay the Insurance Indemnity if the harm has been caused to the Insured due to reasons other than Insured Risks or those listed in the Insurance Indemnity Calculation Table.
6.10. After payment of the Insurance Indemnity, the Insurer shall be entitled to file a subrogation claim against the person who has received the Insurance Indemnity (the Insured or Beneficiary), if:
6.10.1. it is proved through court proceedings that the Insurable Event has been caused as a result of criminal action by the Policyholder, Insured or Beneficiary;
6.10.2. occurrence of the Insured Risk has been caused by the Policyholder, Insured or Beneficiary due to malicious intent or gross negligence;
6.10.3. the Insurer establishes that there was no legal grounds for Insurance Indemnity payment according to the Insurance Contract or the law.