GENERALI

SPLOŠNI POGOJI TUJINA 01-TUJ-01/20

Splošni pogoji za zavarovanje v tujini z asistenco (v nadaljevanju: pogoji) so sestavni del zavarovalne pogodbe, ki jo zavarovalec sklene z zavarovalnico.

IZRAZI V TEH POGOJIH POMENIJO:

Zavarovalec - oseba, ki z zavarovalnico sklene zavarovalno pogodbo in je dolžna plačati premijo.
Zavarovanec - oseba, katere premoženjski interes je zavarovan. Zavarovalec in zavarovanec je ista oseba, razen pri zavarovanju na tuj račun ali na račun tistega, katerega se zavarovanje tiče.
Zavarovalnica - GENERALI zavarovalnica d.d., Kržičeva ulica 3, Ljubljana.
Upravičenec - oseba, ki je upravičena do zavarovalnine oziroma povračila stroškov v primeru nastanka zavarovalnega primera.
Polica - listina o sklenjeni zavarovalni pogodbi.
Pogodba - zavarovalna pogodba, sklenjena med zavarovalcem in zavarovalnico.
Premija - znesek, ki ga zavarovalec mora plačati zavarovalnici po pogodbi.
Zavarovalnina - znesek, ki ga zavarovalnica izplača v okviru določil pogodbe.
Zavarovalna vsota - znesek, ki predstavlja zgornjo mejo obveznosti zavarovalnice ob nastanku zavarovalnega primera.
Franšiza - dogovorjena soudeležba zavarovanca pri zavarovalnem primeru.
Zavarovalni primer - z zavarovalno pogodbo krit škodni dogodek, ki mora biti bodoč, negotov in neodvisen od izključne volje pogodbenikov, z njegovim nastankom pa nastane obveznost zavarovalnice.
Asistenca - pomoč zavarovancu, ki se znajde v težavi v času nahajanja v tujini.
Asistenčni center - asistenčni klicni center zavarovalnice, ki organizira in izvede asistenco, in ki ga je potrebno ob nastopu zavarovalnega primera oziroma potrebe po asistenci za koriščenje storitev po pogodbi obvezno poklicati na njegovo telefonsko številko, ki je navedena v polici.
Tujina - področje, kjer zavarovalnica zavarovancu v skladu s pogodbo nudi zavarovalno kritje. Za tujino se ne šteje domovina.
Domovina - država, kjer ima zavarovanec stalno bivališče. Če zavarovanec nima stalnega bivališča, se upošteva njegovo prijavljeno začasno bivališče.

1. člen – ZAVAROVANE NEVARNOSTI

(1) Zavarovanje nudi naslednja zavarovalna kritja, ki so odvisna od izbranega paketa, navedenega v preglednici kritij na koncu teh pogojev:

1. ASISTENČNE STORITVE:
- dostopnost asistenčnega centra 24 ur na dan 7 dni v tednu,
- organizacijo nujne zdravstvene pomoči,
- organizacijo nujnih zdravstvenih prevozov zavarovanca,
- obveščanje zavarovanca in njegovih najbližjih,
- telefonske stroške za nujne klice na asistenčni center.

2. STROŠKI:

2.1 Medicinska oskrba in obisk zdravnika
Kriti so stroški nujne medicinske oskrbe in obiska zdravnika, ki so posledica nezgode ali bolezni zavarovanca v tujini.

2.2 Zdravljenje
Kriti so stroški nujnega zdravljenja, ki so posledica nezgode ali bolezni zavarovanca v tujini. Obsegajo zdravljenje do dne, ko zdravstveno stanje zavarovanca le temu dovoljuje prevoz v domovino, kjer bo nadaljeval z zdravljenjem. Stroški nujnega zdravljenja vključujejo tudi stroške zdravljenja za akutna poslabšanja, vendar le za naslednje kronične bolezni: bolezni srca, ledvičnih kamnov, žolčnih kamnov, astme in sladkorne bolezni. Kritje stroškov zdravljenja za akutna poslabšanja kroničnih bolezni je omejeno – omejitev je navedena v preglednici kritij, navedenih na koncu teh pogojev.

2.3 Zdravila in medicinski pripomočki
Vključeni so stroški zdravil in zdravniških pripomočkov v primeru nujnega zdravljenja, izdanih na zdravniški recept ali predpisanih na zdravniškem izvidu.

2.4 Nujne zobozdravstvene storitve
V zavarovalno kritje so vključeni stroški za nujno zobozdravstveno pomoč, ki je potrebna za odpravo akutne bolečine zaradi bolezni ali sveže poškodbe zobovja, vključno z ekstrakcijo zoba.

3. DODATNI STROŠKI:

3.1 Prevoz do najbližje bolnišnice in nazaj
Vključeni so stroški prevoza zavarovanca do najbližje bolnišnice ali klinike in nazaj do mesta nastanitve v tujini.

3.2 Prevoz v domovino
Kriti so stroški prevoza obolelega ali poškodovanega zavarovanca v domovino, če zdravstveno stanje zavarovanca dopušča prevoz, pri čemer morata biti za to zavarovalno kritje podana dva pogoja, in sicer, da se za prevoz v domovino predhodno pridobi soglasje asistenčnega centra in da se zavarovanec iz zdravstvenih razlogov ne more vrniti v domovino na način, kot je to prvotno nameraval.

3.3 Prevoz in bivanje za osebo, ki ostane v spremstvu zavarovanca
Kriti so dodatni stroški prevoza in stroški bivanja za osebo, ki na zahtevo oziroma po priporočilu lečečega zdravnika ostane v spremstvu zavarovanca, oziroma stroški prevoza ožjega sorodnika iz domovine do kraja hospitalizacije, če zavarovancu ni mogoče zagotoviti drugačnega spremstva. Če je zavarovanec mladoletna oseba, se krijejo dodatni stroški prevoza in stroški bivanja za osebo, ki ostane v spremstvu zavarovanca, ne glede na to ali je spremstvo priporočil lečeči zdravnik.

3.4 Spremstvo in prevoz mladoletnega otroka
Kriti so stroški prevoza zavarovančevega otroka, mlajšega od 18 let, v domovino, kot tudi stroški prevoza njegovega spremljevalca v primeru zavarovančeve hospitalizacije ali smrti, če otrok ostane brez spremstva odrasle osebe.

3.5 Prevoz družinskega člana
Kriti so stroški obiska zavarovanca. Vključeni so stroški povratne vozovnice za javni prevoz (ekonomski razred) za enega družinskega člana (otrok, partner, starš, brat ali sestra, zakončev starš), če se zavarovanec v tujini nahaja sam in se iz zdravstvenih razlogov ne more vrniti v domovino ter je hospitaliziran več kot 7 dni iz razlogov, kritih po teh pogojih. Če se namesto javnega prevoza najame taksi prevoz, so kriti tudi ti stroški, vendar največ do višine zneska vozovnice za javni prevoz (avtobus ali vlak).

3.6 Prevoz posmrtnih ostankov v domovino zavarovanca
Kriti so stroški prevoza posmrtnih ostankov zavarovanca iz tujine v domovino.

3.7 Vrnitev v domovino
Kriti so stroški organizacije nujne vrnitve v domovino, če član družine (otrok, partner, starš, brat ali sestra, zakončev starš) težje zboli ali umre. Kriti so stroški prestavitve letalske vozovnice oziroma stroški povratnega rednega poleta (ekonomski razred), če prestavitev ni možna ali ni možna vožnja z vlakom (1. razred).
Stroški, navedeni v točkah od 3.3 do 3.5 tega odstavka, se ne povrnejo brez predhodnega soglasja asistenčnega centra.

4. DODATNA KRITJA:

4.1 Preklic leta
Če preklic leta in čakanje na naslednji let traja več kot 6 ur, so kriti stroški, ki nastanejo po tem času, in sicer za:

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nastanitev in prevoz do bližnje nastanitve v okolici letališča, kjer je bil let preklican, restavracijski obrok in napitke, vendar le ob predložitvi originalnih računov, ki so nastali v času med prvotno načrtovanim odhodom leta in dejanskim odhodom leta.

4.2 Izguba/kraja prtljage

a) Če se v času nahajanja zavarovanca v tujini izgubi njegova prtljaga ali je ta ukradena, mu pripada zavarovalnina kot nadomestilo za nastalo škodo. Za izplačilo zavarovalnine mora zavarovanec predložiti natančen opis te prtljage skupaj z datumom nakupa in vrednostjo. Znesek za izplačilo zavarovalnine je odvisen od vrednosti prtljage, izkazane z računi oziroma na podlagi cen, veljavnih na dan nastanka zavarovalnega primera, ter od starosti in obrabe prtljage, pri čemer se upošteva naslednje:
   - prtljaga, stara do 6 mesecev – 100 % izplačilo zavarovalnine po dokazani vrednosti, vendar največ do zneska v preglednici kritij, navedeni na koncu teh pogojev;
   - prtljaga, stara od 6 mesecev do 1 leta – 80 % izplačilo zavarovalnine po dokazani vrednosti, vendar največ do zneska v preglednici kritij, navedeni na koncu teh pogojev.

   Za vsako nadaljnjo začeto leto starosti se izplačilo zavarovalnine zmanjša za dodatnih 10 %.

   Za izplačilo zavarovalnine za prenosne mobilne naprave (telefoni, tablice ipd.), se upošteva znesek, ki ga je zavarovanec za prenosno mobilno napravo dejansko plačal (upoštevajo se tudi razne akcije, vezave naročniškega razmerja ipd.).

b) Za prtljago se štejejo predmeti, namenjeni osebni rabi, ki jih ima zavarovanec s seboj v tujini, pod stalnim nadzorom, in so bili zavarovancu:
   - odtujeni (tatvina/rop), vendar le v primeru, da je dogodek prijavljen lokalni policiji v kraju (državi) nastanka dogodka najkasneje v roku 24 ur in zavarovanec o tem predloži zavarovalnici policijski zapisnik;
   - izgubljeni med transportom, za katerega je odgovorna tretja oseba, vendar le ob predložitvi potrdila prevoznika, da je prtljaga dokončno izgubljena in da je iskanje zaključeno.

4.3 Zamuda prtljage/leta

Če prtljaga/let zavarovanca zamuja več kot 4 ure, so kriti stroški, ki nastanejo po tem času, in sicer v primeru:

a) če pride do zamude leta v tujini, so kriti stroški za restavracijski obrok in napitke, nastali v času med prvotno načrtovanim odhodom leta in dejanskim odhodom leta, vendar le ob predložitvi originalnih računov in potrdila letalskega prevoznika o številu ur zamude in vzroku zamude;
b) če pride do zamude prtljage, so kriti stroški za nakup nujno potrebnih oblačil/obutve, zdravil in toaletnih potrebščin, vendar le ob predložitvi originalnih računov in potrdila letalskega prevoznika o številu ur zamude in vzroku zamude, in sicer samo v primeru, če pride do zamude prtljage v tujini.

4.4 Izguba/kraja osebnih dokumentov

Če zavarovanec izgubi ali so mu bili odtujeni (tatvina/rop) uradni osebni dokumenti, potrebni za povratno potovanje (potni list in/ali osebna izkaznica), so kriti stroški izdelave novih uradnih osebnih dokumentov. V primeru kraje osebnih dokumentov mora zavarovanec dogodek prijaviti lokalni policiji v kraju (državi) nastanka dogodka.

4.5 Predujem varščine

Če je zavarovanec dolžan lokalnim oblastem plačati kazensko varščino, bo zavarovalnica zanj založila varščino, vendar največ do višine zneska, ki je naveden v preglednici kritij, navedeni na koncu teh pogojev. Zavarovanec mora pred nakazilom varščine podpisati zavezo za vračilo tega zneska. Ta znesek je zavarovanec dolžan povrniti v roku 15 dni po prejetju računa zavarovalnice.

4.6 Nujno nakazilo denarja

Če zavarovanec asistenčnemu centru pošlje prošnjo za pomoč za dogodek, ki je krit po teh pogojih, in mora ob tem dogodku plačati tudi druge nepredvidene stroške, mu bo zavarovalnica na njegovo prošnjo nakazala zahtevani znesek denarja v lokalni valuti, vendar največ do višine zneska, ki je naveden v preglednici kritij, navedeni na koncu teh pogojev. Zavarovanec mora pred nakazilom podpisati zavezo za vračilo tega zneska. Ta znesek je zavarovanec dolžan povrniti v roku 15 dni po prejetju računa zavarovalnice.

4.7 Organizacija storitev ob spremembi bivanja v tujini

Če nastanek zavarovalnega primera po teh pogojih zahteva, da mora zavarovanec bivanje v tujini podaljšati, skrajšati ali spremeniti lokacijo, bo asistenčni center organiziral rezervacijske storitve in prenesel naprej vsa potrebna sporočila. Vsa nujna sporočila bo prenesel družini zavarovanca ali na želeni službeni naslov. Asistenčni center bo tudi prilagodil hotelske in letalske rezervacije, rezervacije za izposojo avtomobila ipd..

(2) Za nujne storitve štejejo le tiste storitve, ki so nujno potrebne za ohranjanje življenjskih funkcij ali preprečitev hudega poslabšanja zdravstvenega stanja nenadno obolelega ali poškodovanega zavarovanca.

(3) Skupni znesek stroškov na osebo, vključno s stroški, ki so z medicinskega stališča upravičeni, navedeni v 1. odstavku tega člena, za vse zavarovalne primere, ki nastanejo v času trajanja zdravstvenega zavarovanja, ne sme presegati zneska zavarovalne vsote v preglednici kritij, navedeni na koncu teh pogojev. Ne glede na navedeno je zavarovalno kritje stroškov zdravljenja za akutna poslabšanja kroničnih bolezni in nujnih zobozdravstvenih storitev omejeno in je podano le do zneska, ki je v preglednici kritij, navedeni na koncu teh pogojev. Navedena omejitev se v primeru akutnega poslabšanja kroničnih bolezni in nujnih zobozdravstvenih storitev nanaša na vsa zavarovalna kritja po teh pogojih, zato zavarovalnina v teh primerih lahko skupaj znaša le do zneska omejitve.

(4) Ko je celotna zavarovalna vsota za posamezno kritje po posamezni polici izplačana, to zavarovalno kritje preneha.

(5) Zavarovalnica in asistenčni center na noben način ne odgovarjata za ravnanja izvajalcev storitev, ki se organizirajo in plačajo v okviru zavarovalnega kritja po teh pogojih. Odgovornost zavarovalnice ali asistenčnega centra za morebitno nekvalitetno izvedbo del ali storitev s strani posameznih izvajalcev je izključena.

(6) Zavarovanec mora z vso skrbnostjo paziti, da preprečuje izgube, škodo, nezgode, telesne poškodbe ali bolezni. Prav tako mora varovati, hraniti in/ali poiskati svojo lastnino ter po svojih močeh omejevati stroške.

2. člen – ZAVAROVANCI

(1) Pri posameznem zavarovanju je zavarovanec oseba, ki je navedena v polici.

(2) Pri družinskem zavarovanju so zavarovanci osebe, ki so navedene v polici in živijo v skupnem gospodinjstvu ter so med seboj v družinskem razmerju: zakonec ali partner iz druge pravno priznane skupnosti in njuni otroci, pastorki, rejenci ali posvojenci do 26. leta starosti.

(3) Pri skupinskem zavarovanju so zavarovanci vse osebe, ki so navedene v polici oziroma v prilogi k polici in predstavljajo skupino. Skupina pomeni 9 ali več oseb, ki skupaj istočasno odhajajo na isto destinacijo v tujino. Če je manj kot 9 oseb,

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se uporabljajo določila za posamezno zavarovanje, če ni drugače dogovorjeno.

(4) Zavarovanci po teh pogojih so lahko le osebe do dopolnjenega 75. leta starosti. Z ustreznim doplačilom na premijo se lahko zavarujejo tudi osebe, starejše od 75 let.

3. člen – IZKLJUČITVE

(1) V celoti so izključene vse obveznosti zavarovalnice, če je primer nastal kot posledica:

1. potresa;
2. aktivnega služenja zavarovanca v oboroženih silah;
3. aktivnega sodelovanja zavarovanca v vojni (razglašeni ali nerazglašeni), invaziji, dejanju tujega sovražnika, sovražnosti, državljanski vojni, terorizmu, uporu, izgredu, revoluciji, javnem shodu, zborovanju ali vstaji;
4. samomora ali poskusa samomora zavarovanca;
5. dogodkov, ki so na kakršen koli način povezani z zavestnim samopoškodovanjem ali povzročitvijo bolezni, brezumnim ravnanjem, dogodkov, do katerih pride, ko je zavarovanec pod vplivom alkohola ali drog ali drugih prepovedanih snovi oziroma dogodkov, kjer se zavarovanec po nepotrebnem izpostavi nevarnosti (razen v primeru poskusa rešitve človeškega življenja);
6. vožnje zavarovanca z motornimi in drugimi vozili brez ustreznih uradnih dovoljenj (vozniško, prometno dovoljenje);
7. namernega ali naklepnega kaznivega dejanja s strani zavarovanca;
8. dogodkov, ki so vezani na kakršen koli prispevek pri uporabi, sprostitvi ali grožnjah s kakršnim koli jedrskim orožjem ali napravami, kemičnimi ali biološkimi snovmi, kot tudi dogodkov, ki so na kakršen koli način povzročeni ali h katerim so prispevala dejanja vojne, uporov, vstaj ali nemirov;
9. radioaktivnih sevanj, epidemije, pandemije.

(2) Zavarovanje tudi ne nudi asistenčnih storitev in ne krije nobenih stroškov v povezavi z dogodki, ki nastanejo kot posledica:

1. priprave ali udeležbe:
   - na avto-moto tekmovanjih, pri vožnjah po dirkališčih in pripadajočih treningih ter rekreativni udeležbi;
   - v športnem letalstvu, padalstvu, pri letenju z zmaji, z jadralnimi letali;
   - pri alpinizmu;
   - pri jamarstvu;
2. rekreativne udeležbe (razen, če je posamezna aktivnost posebej dogovorjena in to izhaja iz police):
   - pri planinarjenju in trekingu nad 3.000 metrov nadmorske višine;
   - pri potapljanju in podvodnem ribolovu;
   - pri kajtanju (kitesurfing, kiteboarding);
   - pri smučanju in deskanju na snegu izven urejenih smučišč ali heliskiingu;
   - pri prostem plezanju;
   - pri spustu s kolesi (npr. downhill, all mountain, enduro,…);
   - na drugih športnih tekmovanjih in treningih;
3. izvajanja ekstremnega športa ali če so v neposredni zvezi s še posebej nevarno dejavnostjo, ki je povezana z nevarnostjo, ki precej presega običajno tveganje pri nahajanju v tujini;
4. nastopa na ekspedicijah v neosvojena ali neraziskana področja;
5. telefonskih stroškov, razen nujnih klicev na asistenčni center;
6. izgube ali dogodka, za katere v teh pogojih ni izrecno navedeno, da je zanje podano zavarovalno kritje;
7. telesne poškodbe, bolezni, smrti, izgube, stroškov ali kakršne koli druge obveznosti, povezane z virusom HIV (Human Immunodeficiency Virus) ali aidsom (Acquired Immune Deficiency Syndrome) oziroma kakršnim koli podobnim drugim sindromom, ne glede na to, kako se imenuje, razen če se zavarovanec okuži med medicinsko preiskavo, preizkusom ali zdravljenjem (vendar le, če to ni povezano z jemanjem drog ali spolno prenosljivimi boleznimi).

(3) Zavarovalnica ne krije stroškov v naslednjih primerih:

1. če se zavarovanec na zahtevo zavarovalnice ne pusti pregledati zdravniku, ki ga imenuje zavarovalnica ali njeni predstavniki;
2. za storitve, ki jih nudi kateri koli izvajalec, ki ni pogodbeni partner zavarovalnice ali zavarovalnica zanj ni jamčila, ter za storitve, opravljene brez pooblastila in/ali udeležbe oziroma odobritve asistenčnega centra;
3. če so posledica kakršnega koli zračnega prevoza zavarovanca, razen če je potoval kot potnik, ki je plačal prevoznino;
4. če so posledica dejstva, da zavarovanec ni z vso dolžno skrbnostjo pazil, da bi preprečil izgubo, škodo, nezgode, telesne poškodbe ali bolezni sebe ali svoje lastnine;
5. ki bi jih zavarovanec moral plačati tudi, če se dogodek, v katerem je posredoval asistenčni center, ne bi bil zgodil.

(4) Izključene so vse obveznosti zavarovalnice v primeru dajanja neresničnih podatkov zavarovalca oziroma zavarovanca o trajanju zadrževanja v tujini, o okoliščinah dogodka, poškodbe ali vrsti bolezni ter kakršnih koli prevar ali ponaredb.

(5) Od zavarovalnice se ne more zahtevati, da zagotovi zavarovancu storitve, kadar se le-ta nahaja na območju, kjer obstaja tveganje vojnih, političnih ali drugih okoliščin, ki bi takšne storitve onemogočile ali pa bi bile upravičeno neizvedljive.

(6) Izključene so vse obveznosti zavarovalnice v primeru, če se zavarovanec ne ravna po navodilih, ki jih dobi od asistenčnega centra.

(7) Če zavarovanci, ko se znajdejo v težavi, ne pokličejo na asistenčni center, se šteje, da zavarovalni primer po teh pogojih ni nastal, zato zavarovalnica v tem primeru ni dolžna povrniti nikakršnih stroškov.

4. člen – POSEBNE IZKLJUČITVE

(1) Poleg splošnih izključitev iz 3. člena teh pogojev veljajo za zavarovalna kritja, ki se nanašajo na Zdravljenje, Zdravila in zdravniške pripomočke, Nujne zobozdravstvene storitve in Prevoz v domovino, še naslednje posebne izključitve, ki se nanašajo na naslednja zdravljenja, postavke, pogoje, dejavnosti in z njimi povezane ali iz njih izvirajoče stroške:

1. zahtevki, povezani s posledicami uživanja alkohola, jemanja drog ipd. Če se ta dejstva ugotovijo naknadno, si zavarovalnica pridržuje regresno pravico za vse stroške, ki jih je na podlagi takšnih zahtevkov že izplačala;
2. poslabšanja že obstoječih ali ponavljajočih se bolezni, zaradi katerih je zavarovanec že bil zdravljen ali so se pojavile in niso bile v celoti odpravljene pred začetkom zavarovanja oziroma pred odhodom v tujino, ter vseh kroničnih bolezni in stanj, razen tistih, ki so navedene v 2.2 točki 1. odstavka 1. člena teh pogojev;
3. ponavljajočih se izvinov in izpahov ter zdravljenja poškodb, ki so nastale pred začetkom trajanja zdravstvenega zavarovanja oziroma pred odhodom v tujino;
4. zobozdravstvenih storitev, razen nujne zobozdravstvene pomoči, ki je potrebna za odpravo akutne bolečine zaradi bolezni ali sveže poškodbe zobovja, vključno z ekstrakcijo zoba, do zneska v preglednici kritij, navedeni na koncu teh pogojev;
5. prevoza za težave, ki se lahko zdravijo na kraju dogodka;
6. zdravljenja, ki ga nudi oseba, s katero zavarovanec potuje;
7. zdravljenje, ki ga nudi oseba-zdravnik, ki se naključno znajde na kraju dogodka, pred prihodom pristojnega zdravnika.
8. nalezljivih spolnih bolezni;
9. nosečnosti, rednih pregledov v času nosečnosti, tipičnih težav v času nosečnosti, poroda po 37. tednu nosečnostne starosti, razen v primeru reševanja življenja matere oziroma otroka;
10. načrtovane prekinitve nosečnosti;
11. posebne storitve v bolnišnici – nadstandard, kot je enoposteljna soba, TV, posebne nastanitve itn.;

GENERALI zavarovalnica d.d., Kržičeva ulica 3, 1000 Ljubljana | Matična številka: 5186684000 | ID za DDV:88725324 I Okrožno sodišče v Ljubljani I
Osnovni kapital 39.520.347,18 EUR I Družba pripada zavarovalniški skupini Generali Group.

12. operacije ali zdravljenja, ki se lahko prestavi brez kakršnih koli posledic na čas vrnitve v domovino;
13. zahtevki, ki nastanejo po vrnitvi v domovino;
14. stroški optičnih pripomočkov, razen če so nastali kot posledica nujnega medicinskega primera;
15. zdravljenje, ki ga je opravil zdravnik brez uradno priznanega dovoljenja;
16. stroški, nastali zaradi zdravljenja, ki ni potrjeno z zdravniškim izvidom;
17. stroški prevoza, če se je zavarovanec po mnenju lečečega zdravnika zdravstveno sposoben vrniti v domovino na prvotno načrtovani način;
18. nezgode pri delu ali kateri koli drugi dejavnosti, pri kateri so potrebni povečani fizični napori, če to v polici ni posebej dogovorjeno;
19. duševnih ali vedenjskih motenj;
20. dogodkov, nastalih med odhodom v tujino, na katerega se zavarovanec odpravi v nasprotju z zdravniškim nasvetom;
21. dogodkov, ki so povezani s kozmetičnimi operacijami za popravo videza, razen če je kirurški poseg nujen zaradi akutne bolezni ali iznakaženosti, ki jo krije to zavarovanje
22. predvidena redna cepljenja.

(2) Poleg splošnih izključitev iz 3. člena teh pogojev veljajo za zavarovalna kritja, ki se nanašajo na Preklic leta, Izgubo/krajo prtljage, Zamudo prtljage/leta in Izgubo/krajo osebnih dokumentov še naslednje posebne izključitve, ki se nanašajo na naslednje postavke, pogoje, dejavnosti (in z njimi povezane ali iz njih izvirajoče stroške):

1. dodatna oprema za vozila ali čolne, izgube ali kraje motornih vozil, zračnih in vodnih plovil, kot tudi na vso pripadajočo dodatno opremo, jadralnih letal, zmajev, padal in jadrnic za jadranje na ledu;
2. predmeti, ki so nenadzorovani puščeni na kraju, ki je javno dostopen in jih je zavarovanec odložil, založil, izgubil, pozabil ali izpustil iz rok;
3. izguba ali kraja, ki ni prijavljena policiji, letalski družbi, linijski družbi ali njihovemu zastopniku v roku 24 ur po odkritju in pridobitvi pisnega poročila;
4. izguba, ki je bila posledica zaplembe ali pridržanja na carini oziroma s strani drugih organov oblasti;
5. kraja predmetov iz nenadzorovanih vozil, razen če so v zaklenjenem prtljažniku, ki mora biti ločen od prostora za potnike ali, če vozilo nima prtljažnika, v zaklenjenem vozilu in na mestu, ki ni vidno od zunaj, pod pogojem, da je vozilo parkirano na varovanem parkirnem prostoru ali v zaklenjeni garaži ter, če je iz policijskega zapisnika razvidno, da je prišlo do vloma v to vozilo;
6. kraja predmetov v vozilu kot posledice kraje tega vozila;
7. zahtevki zaradi izgube ali kraje iz bivališča, razen če obstajajo dokazi o nasilnem vstopu, ki ga potrdi tudi policijsko poročilo;
8. prenosni telefon, fotoaparat, fotografska oprema (stojala, objektivi, leče, ...), kamera, MP3 predvajalnik in prenosni računalnik, razen če so bili zavarovancu odtujeni z ropom ali z roparsko tatvino;
9. denar, čeki, kreditne/debetne kartice, vrednostni papirji, vozovnice, dragocenosti in nakit, razen če so bili shranjeni v hotelskem sefu ali v zaklenjenem sobnem sefu;
10. izguba kontaktnih leč, očal, slušnih aparatov, zobna ali druga protetika, kozmetika, starine, glasbila, rokopisi, pokvarljivo blago, živali in kolesa;
11. izguba stvari, ki si ga je zavarovanec izposodil, najel ali ga zakupil;
12. izguba ali kraja predmetov ali pripomočkov, potrebnih za izvajanje poklicne dejavnosti, motorne opreme in drugih predmetov, ki jih zavarovanec uporablja v povezavi s svojo poslovno dejavnostjo, obrtjo, poklicem ali službo;
13. izguba ali kraja športne opreme ali športnih oblačil, med njihovo uporabo;
14. devalvacije valute ali finančnega primanjkljaja zaradi napak ali opustitev med bančno transakcijo;
15. stroški prevzema zamujene prtljage;
16. stroški zamude prtljage pri vrnitvi ali vračanju v domovino;
17. plačila za prve 4 ure zamude leta;
18. plačila za prvih 6 ur preklica leta;
19. zamude kot posledice dejstva, da zavarovanec ni prispel na mesto odhoda pravočasno glede na okoliščine, ki so mu bile znane v tistem času;
20. zamude kot posledice dejstva, da zavarovanec ni predložil ustreznih zahtevanih dokumentov;
21. zamude, ki je nastala kot posledica začasne ustavitve ali preklica storitve s strani katerega koli uradnega organa ali kot posledica stavke;
22. stroški, ki jih povrne letalska družba.

5. člen – IZKLJUČITVE TERORISTIČNIH DEJANJ

(1) Ne glede na druga določila pogodbe s tem zavarovanjem ni krita škoda, ki je nastala v neposredni ali posredni povezavi s terorističnim dejanjem, niti kateri koli stroški, ki so nastali kot posledica te škode, in sicer niti v primeru, če je skupaj s terorističnim dejanjem na nastanek škode vplival še kak drug vzrok ali dejanje.

(2) Šteje se, da je teroristično dejanje vsako nasilno dejanje ali dejanje, ki ogroža človeško življenje, premično oziroma nepremično premoženje ali infrastrukturo, in sicer s silo, nasiljem ali grožnjo, je izvedeno zaradi političnih, verskih, ideoloških ali podobnih namenov ter ima namen vplivati ali vpliva na vlado kakšne države ali ima namen ustrahovati ali ustrahuje javnost oziroma katerikoli njen del ali pa ima tak učinek. Za teroristično dejanje se šteje dejanje, ki je izvedeno samostojno, kot tudi tisto, ki je izvedeno v povezavi s katero koli organizacijo ali oblastjo.

(3) Iz kritja so izključeni tudi škoda in stroški, nastali zaradi preprečevanja oziroma zatiranja terorističnih dejanj.

6. člen – KRAJ ZAVAROVANJA

Zavarovalno kritje je veljavno samo v tujini.

7. člen – VELJAVNOST ZAVAROVANJA

(1) Zavarovalna pogodba je sklenjena, ko pogodbenika podpišeta polico ali potrdilo o kritju.

(2) Zavarovalnica ima obveznost samo tedaj, če pride do škodnega dogodka po začetku in pred koncem zavarovalnega kritja. Če ni drugače dogovorjeno, se obveznost zavarovalnice začne tisti dan, ki je v polici označen kot začetek zavarovanja, pod pogojem, da je do takrat plačana premija, sicer pa začne naslednji dan po dnevu, ko je plačana premija. Obveznost zavarovalnice preneha z iztekom dneva, ki je v polici naveden kot dan poteka zavarovanja.

(3) Če je dogovorjeno, da je treba premijo plačati:

1) ob sklenitvi pogodbe in premija ni bila plačana, začne teči obveznost zavarovalnice, da izplača v pogodbi dogovorjeno zavarovalnino ali odškodnino naslednji dan po vplačilu premije;
2) po sklenitvi pogodbe, začne teči obveznost zavarovalnice, da izplača v pogodbi določeno zavarovalnino ali odškodnino, na dan, ki je v pogodbi določen kot dan začetka zavarovanja.

(4) Če trajanje zavarovanja ni določeno v pogodbi oziroma če je v pogodbi dogovorjen rok trajanja z možnostjo, da se pogodba podaljšuje za enako časovno obdobje, sme vsaka stranka od nje odstopiti z dnem zapadlosti premije, s tem da mora o tem pisno obvestiti drugo stranko najmanj tri mesece pred zapadlostjo premije.

(5) Če je zavarovanje sklenjeno za več kot tri leta, sme po preteku tega časa vsaka stranka z odpovednim rokom šestih mesecev odstopiti od pogodbe, tako da to pisno sporoči drugi stranki.

(6) Če je bil glede na dogovorjeni čas zavarovanja priznan popust na premijo, zavarovanje pa je prenehalo pred potekom tega časa, lahko zavarovalnica terja razliko do tiste premije, ki bi jo moral zavarovalec plačati, če bi se bila pogodba sklenila samo za toliko časa, kolikor je dejansko trajala. Če je bil priznan popust na premijo na podlagi sklenjenih več pogodb pri zavarovalnici (paketni popust), lahko v primeru prenehanja posamezne ali vseh od teh pogodb (ne glede na razlog) zavarovalnica paketni popust

ustrezno zniža oziroma ukine, zavarovalec pa mora plačevati temu ustrezno premijo.

(7) Če pogodbo odpove zavarovalnica, lahko skupaj z odpovedjo zavarovalcu ponudi sklenitev nove istovrstne pogodbe. Zavarovalec ima pravico, da v 30 dneh po prejemu odpovedi in ponudbe za sklenitev nove pogodbe zavarovalnici sporoči, da s sklenitvijo nove pogodbe ne soglaša. V tem primeru zavarovalno razmerje z iztekom tekočega zavarovalnega leta preneha. Če zavarovalec ob prejemu odpovedi in ponudbe za sklenitev nove pogodbe zavarovalnici ne sporoči ničesar, se šteje, da se potrebe zavarovalca niso spremenile in da se zavarovalec s ponudbo za sklenitev nove pogodbe strinja, zato se zavarovalno razmerje z iztekom tekočega zavarovalnega leta nadaljuje po novi pogodbi. Na podlagi sklenitve nove pogodbe zavarovalnica pošlje zavarovalcu novo polico.

(8) V primeru sklepanja na daljavo je pogodba sklenjena s plačilom premije, kar zavarovalec dokazuje s potrdilom o plačilu premije. Zavarovalec ima kot potrošnik pravico, da v 14 dneh obvesti zavarovalnico, da odstopa od pogodbe, ne da bi mu bilo treba navesti razlog za svojo odločitev. Zavarovalnica je v tem primeru upravičena obdržati premijo za vsak dan, ko je zagotavljala zavarovalno kritje. Odstop mora biti pisen in vložen na zavarovalnico do izteka roka, pri čemer se šteje, da je vložen v roku, če je do izteka roka priporočeno oddan na pošti. Zavarovalec nima pravice do odstopa od pogodbe po tem odstavku pri zavarovalnih pogodbah z veljavnostjo, krajšo od enega meseca.

(9) Pri celoletnem zavarovanju za večkratne odhode zavarovanca v tujino zavarovanje velja za neomejeno število odhodov v tujino v enem zavarovalnem letu, s tem, da posamezno zadrževanje v tujini ne sme trajati več kot 90 dni.

(10) Zavarovanje je treba skleniti pred odhodom zavarovanca v tujino. Če se ob sklenitvi zavarovanec nahaja v tujini, zavarovalno kritje po teh pogojih prične veljati šele po preteku 5 dni od dneva, ki je v polici naveden kot začetek zavarovanja.

(11) Zavarovalec lahko odpove zavarovalno pogodbo v času, ko zavarovalno kritje še ni nastopilo – pred začetkom zavarovanja, kot je navedeno v polici.

(12) Odpoved ni možna po začetku zavarovalnega kritja, razen v primeru sklepanja na daljavo.

8. člen – PLAČILO PREMIJE IN POSLEDICE NEPLAČILA PREMIJE

(1) Premijo oziroma 1. obrok mora zavarovalec plačati ob sklenitvi pogodbe. Za plačilo ob sklenitvi pogodbe šteje tudi plačilo, ki je izvršeno najpozneje do dneva zapadlosti, ki je naveden na terjatvenem dokumentu. V tem primeru je zavarovalno kritje zagotovljeno od dneva in ure, ki sta določena kot začetek zavarovanja. Če premija (oziroma 1. obrok) do dneva zapadlosti na terjatvenem dokumentu ni plačana v celoti, je zavarovalno kritje zagotovljeno šele z naslednjim dnem po celotnem plačilu.

(2) Premije za naslednja zavarovalna leta (oz. 1. obrok v naslednjem zavarovalnem letu) pri večletnih zavarovanjih pa mora zavarovalec plačati prvi dan vsakega nadaljnjega zavarovalnega leta. Če ni drugače dogovorjeno, je dinamika plačil za naslednja zavarovalna leta enaka kot v prvem zavarovalnem letu.

(3) Če je dogovorjeno, da se premija plačuje v obrokih ali za nazaj, se lahko obračuna doplačilo. Če obrok ni plačan do dneva zapadlosti, ima zavarovalnica pravico zaračunati zakonske zamudne obresti in zahtevati takojšnje plačilo vseh še nezapadlih obrokov.

(4) Če je premija plačana po pošti ali banki, za čas plačila velja dan, ko je bil podan nalog za plačilo pošti ali banki. Če ob plačevanju premije ni naveden točen sklic, iz katerega bi bilo razvidno, katera premija oziroma kateri obrok premije in po kateri pogodbi se plačuje, se šteje, da se plačuje tista neplačana premija oziroma tisti obrok premije, ki je po dnevu zapadlosti najstarejši, in sicer ne glede na vrsto pogodbe, ki je sklenjena pri zavarovalnici.

(5) V primeru prenehanja pogodbe zaradi neplačane zapadle premije mora zavarovalec plačati premijo za čas do dneva prenehanja pogodbe. Zavarovalec je dolžan plačati celotno premijo za tekoče zavarovalno leto, če je do dneva prenehanja veljavnosti pogodbe nastal zavarovalni primer, za katerega mora zavarovalnica plačati odškodnino ali zavarovalnino. Zavarovalec je dolžan povrniti tudi popust na premijo, ki mu je bil priznan za dogovorjeni čas zavarovanja, kot je opredeljeno v 6. odstavku 7. člena teh pogojev.

(6) Zavarovalnica ima pravico, da ob kakršnem koli izplačilu iz zavarovanja od zavarovalnine ali odškodnine odtegne vse zapadle in neplačane premije tekočega zavarovalnega leta, pa tudi druge zapadle obveznosti zavarovalca do zavarovalnice iz preteklih let.

(7) Obveznost zavarovalnice, da izplača zavarovalnino ali odškodnino, preneha v primeru, če zavarovalec do zapadlosti ne plača zavarovalne premije, ki je zapadla po sklenitvi pogodbe, in tega tudi ne stori kdo drug, ki je za to zainteresiran, po 30 dneh od dneva, ko je bilo zavarovalcu vročeno priporočeno pismo zavarovalnice z obvestilom o zapadlosti premije, pri čemer pa ta rok ne more izteči prej, preden ne preteče 30 dni od zapadlosti premije.

(8) Zavarovalnica lahko po izteku roka iz 7. odstavka tega člena, če je zavarovalec v zamudi s plačilom premije, ki jo je treba plačati po sklenitvi pogodbe oziroma druge in naslednjih premij, razdre zavarovalno pogodbo brez odpovednega roka, s tem da razdrtje zavarovalne pogodbe nastopi z iztekom roka iz 7. odstavka tega člena in s prenehanjem zavarovalnega kritja, če je bil zavarovalec na to opozorjen v priporočenem pismu z obvestilom o zapadlosti premije in prenehanju zavarovalnega kritja.

(9) Če zavarovalec, v primerih ko zavarovalnica ni razdrla zavarovalne pogodbe, plača premijo po izteku roka 7. odstavka tega člena, vendar v enem letu od zapadlosti premije, je zavarovalnica dolžna, če nastane zavarovalni primer, plačati odškodnino ali zavarovalnino od 24. ure po plačani premiji in zamudnih obresti. Če zavarovalec premije v tem roku ne plača, pogodba preneha veljati s potekom zavarovalnega leta.

(10) Na premijo se zaračunavajo zakonsko predpisane dajatve (davščine, takse ipd). Če se med trajanjem zavarovanja spremenijo ali uvedejo nove dajatve (nova pristojbina, sprememba davčne stopnje ipd.), te spremembe vplivajo na višino dogovorjene premije.

(11) Zavarovalnica zaračunava stroške papirnatega poslovanja in drugih administrativnih storitev skladno s cenikom, ki je objavljen na www.generali.si/ceniki.

9. člen – VRAČILO PREMIJE

(1) V primeru odpovedi pogodbe zavarovalnica vrne plačano premijo.

(2) Ne glede na razlog za prenehanje pogodbe ima zavarovalec pravico terjati vračilo premije za preostalo dobo trajanja zavarovanja samo, če za to zavarovalno obdobje ni bilo prijavljenega zavarovalnega primera. Če je bil zavarovalni primer prijavljen pozneje, mora zavarovalec ta znesek premije zavarovalnici na njen poziv vrniti.

(3) Pri izračunu vrnjenega dela premije se upoštevajo administrativni stroški skladno s cenikom, ki je objavljen na www.generali.si/ceniki.

10. člen – NEVARNOSTNE OKOLIŠČINE

(1) Pred sklenitvijo kakor tudi med trajanjem pogodbe mora zavarovalec prijaviti zavarovalnici vse okoliščine, ki so pomembne za ocenitev nevarnosti in za katere je vedel, oziroma bi moral vedeti. Za okoliščine, ki so pomembne za ocenitev nevarnosti, štejejo zlasti okoliščine, ki so zavarovalcu znane in na podlagi katerih je določena in obračunana premija, kakor tudi tiste, navedene v pogodbi.

(2) Zavarovalec je dolžan zavarovalnico obvestiti o vsaki spremembi okoliščin, ki utegnejo biti pomembne za ocenitev nevarnosti. Prav tako je dolžan brez odlašanja zavarovalnico obvestiti o povečanju nevarnosti, če se je nevarnost povečala zaradi katerega od njegovih ravnanj; če pa je do povečanja nevarnosti prišlo brez njegovega sodelovanja, jo

mora obvestiti v 14 dneh, odkar je za to zvedel. Če je povečanje nevarnosti tolikšno, da zavarovalnica ne bi sklenila pogodbe, če bi bilo tako stanje takrat, ko je bila sklenjena, lahko odstopi od pogodbe. Če pa je povečanje nevarnosti tolikšno, da bi zavarovalnica sklenila pogodbo samo proti večji premiji, če bi bilo tako stanje takrat, ko je bila sklenjena, lahko predlaga zavarovalcu novo višino premije. Če zavarovalec ne privoli v novo višino premije v 14 dneh od prejema takega predloga, preneha pogodba po samem zakonu. Vendar pogodba ostane v veljavi in zavarovalnica ni več upravičena predlagati zavarovalcu nove višine premije ali odstopiti od pogodbe, če teh svojih pravic ne izkoristi v 30 dneh od dneva, ko je kakor koli izvedela za povečanje nevarnosti, ali če še pred iztekom tega roka na kakšen način pokaže, da soglaša s podaljšanjem pogodbe (če sprejme premijo, izplača zavarovalnino za zavarovalni primer, ki je nastal po tem povečanju ipd.).

11. člen – DOLŽNOSTI ZAVAROVANCA PO ZAVAROVALNEM PRIMERU

(1) Po nastanku zavarovalnega primera mora zavarovanec takoj storiti vse, kar je v njegovi moči, da bi preprečil nadaljnje nastajanje škode. Pri tem mora upoštevati navodila asistenčnega centra in poskušati omejiti stroške po svojih najboljših močeh.

(2) Zavarovanec mora o nastalem škodnem dogodku obvestiti asistenčni center najkasneje v treh (3) dneh od dneva, ko zanj izve.

(3) Zavarovanec mora dati asistenčnemu centru vse podatke in druge dokaze, ki jih ima na voljo in so nujno potrebni za organizacijo asistence (pomoči), ugotavljanje vzroka, obsega in višine škode ter drugo dodatno dokumentacijo na zahtevo zavarovalnice. V vsakem primeru mora zavarovanec ravnati po navodilih, ki jih dobi od asistenčnega centra ali zavarovalnice. Zavarovanec mora hraniti vse originalne račune, potrdila, uradno zdravstveno dokumentacijo, ki opravičuje nujnost zdravljenja, vstopnice, pogodbe, potrdila o plačilih cestnine (predornine), potrdila o plačilih s kreditno kartico in preostala morebitna dokazila za predložitev na zahtevo asistenčnega centra ali zavarovalnice.

(4) Zavarovanec vsa potrdila, informacije, soglasja, uradne prevode dokumentacije in dokazila, ki jih zahteva asistenčni center ali zavarovalnica, predloži na lastne stroške. Zavarovanec mora obrazec za izplačilo zavarovalnine izpolniti in poslati zavarovalnici v tridesetih (30) dneh od nastanka stroška. Ta rok je mogoče podaljšati na podlagi predhodnega dovoljenja asistenčnega centra ali zavarovalnice, kadar spremna dokumentacija ni na voljo pravočasno. Vsi predloženi dokumenti v zvezi z nastankom zavarovalnega primera morajo biti v izvirniku.

(5) Če zavarovanec svojih obveznosti iz tega člena v dogovorjenem roku ne izpolni, zavarovalnica lahko odkloni plačilo zavarovalnine, če zaradi te opustitve ne more ugotoviti nastanka zavarovalnega primera.

(6) Če zavarovanec po svoji krivdi zavarovalnici ne prijavi nastanka zavarovalnega primera v času in na način, ki je določen s temi pogoji, mora zavarovalnici vrniti morebitno škodo, ki jo le-ta ima zaradi tega.

(7) Če je zavarovanec nujne zdravstvene storitve plačal sam, mu zavarovalnica vrne stroške skladno s 1. členom teh pogojev po predložitvi zahtevane dokumentacije, vendar le pod pogojem, da je o nastanku škodnega dogodka predhodno obvestil asistenčni center.

12. člen – OBVEZNOST ZAVAROVALNICE

(1) Asistenčne storitve in stroške, ki so kriti v skladu s 1. členom teh pogojev, plača zavarovalnica neposredno izvajalcem.

(2) V primeru, ko nujne zdravstvene storitve ali ostale stroške odobrene s strani asistenčnega centra plača zavarovanec sam, mora zavarovalnica to vrniti kot zavarovalnino v roku 14 dni, šteto od dneva, ko razpolaga z vso dokumentacijo, na podlagi katere lahko odloča o temelju in višini zahtevka. Če znesek njene obveznosti ni ugotovljen v tem roku, mora zavarovalnica zavarovancu oziroma upravičencu na njegovo zahtevo izplačati nesporni del svoje obveznosti kot predujem.

(3) Zavarovalnica vrne plačani znesek po referenčnem tečaju Evropske centralne banke (ECB) na dan plačila zavarovalnine, vendar največ do zneska v preglednici kritij, navedeni na koncu teh pogojev.

(4) Predhodno določilo tega člena ne velja, če zavarovanec dostavi dokazilo, iz katerega je razviden dejanski znesek stroškov v EUR na dan nastanka zavarovalnega primera.

(5) Zavarovalnica lahko terjatev zavarovanca za zavarovalnino pobota s terjatvijo, ki jo ima zavarovalnica do zavarovanca iz katerega koli naslova.

13. člen – PRAVICE ZAVAROVALNICE

(1) V primeru nezgode, ki jo povzroči tretja oseba, ima zavarovalnica od povzročitelja nezgode pravico terjati povračilo stroškov, ki jih je plačala zavarovancu, asistenčnemu centru ali izvajalcu.

(2) Zavarovalnica si pridržuje pravico do povračila vseh nastalih stroškov v primeru, ko se naknadno ugotovi, da je zavarovalni primer nastal zaradi dogodkov, navedenih v 3. členu teh pogojev.

14. člen – OMEJITEV OBVEZNOSTI ZARADI DRUGIH ZAVAROVANJ

Če je zavarovanec zavarovan še po kateri drugi pogodbi pri drugi zavarovalnici, je zavarovanec dolžan najprej uveljavljati svoje pravice po drugi pogodbi. Zavarovalnica je po tej pogodbi zavezana k plačilu samo, če druga zavarovalnica ne pokrije škode zavarovancu oziroma je zavezana k doplačilu zneska razlike med izplačilom zavarovalnine druge zavarovalnice in škodo, obračunano po tej pogodbi.

15. člen – IZVEDENSKI POSTOPEK

(1) Vsaka pogodbena stranka lahko zahteva, da določena sporna dejstva ugotavljajo izvedenci.

(2) Vsaka stranka imenuje enega izvedenca od oseb, ki s strankami niso v delovnem ali sorodstvenem razmerju. Imenovana izvedenca pred začetkom dela imenujeta tretjega izvedenca, ki svoje mnenje poda samo, kadar se ugotovitve prvih dveh izvedencev razlikujejo in zgolj v mejah njunih ugotovitev.

(3) Vsaka stranka nosi stroške za izvedenca, ki ga je imenovala, za tretjega izvedenca si pogodbeni stranki stroške delita.

(4) Končne ugotovitve so obvezujoče za obe pogodbeni stranki.

16. člen – SPREMEMBA ZAVAROVALNIH POGOJEV ALI PREMIJSKEGA CENIKA

(1) Če zavarovalnica spremeni zavarovalne pogoje ali premijski cenik, mora o spremembi pisno obvestiti zavarovalca vsaj 60 dni pred potekom tekočega zavarovalnega leta.

(2) Zavarovalec ima pravico, da v 30 dneh po prejemu obvestila odpove zavarovalno pogodbo. Pogodba preneha veljati s potekom tekočega zavarovalnega leta.

(3) Če zavarovalec ne odpove pogodbe, se ta z začetkom prihodnjega leta spremeni skladno z novimi zavarovalnimi pogoji ali premijskim cenikom.

(4) Zavarovalnica lahko v 30 dneh po ugotovitvi, da so ji bili ob sklepanju pogodbe posredovani netočni podatki (na primer neustreznost podatkov o nevarnostnih okoliščinah, podatkov o predmetu zavarovanja, podatkov o predhodnem škodnem dogajanju, podatki o stranki idr.) temu ustrezno popravi polico in o tem obvesti zavarovalca. Če zavarovalec s popravki ne soglaša, lahko odstopi od pogodbe v 14 dneh od prejema popravka police. Če zavarovalec v tem roku od pogodbe ne odstopi, šteje, da s temi popravki soglaša, zato pogodba od izteka tega roka dalje velja z upoštevanimi popravki, kot izhaja iz popravka police.

17. člen – NAČIN OBVEŠČANJA

(1) Dogovori o vsebini zavarovalne pogodbe so veljavni le, če so sklenjeni v pisni obliki.

(2) Vsa obvestila in izjave, ki jih je treba dati po določbah zavarovalne pogodbe, morajo biti pisne.

(3) Obvestilo ali izjava je dana pravočasno, če se pošlje pred potekom roka s priporočenim pismom.

(4) Izjava, ki jo je treba dati drugemu, velja šele tedaj, ko jo ta prejme.

18. člen –SPREMEMBA NASLOVA IN VROČANJE

(1) Zavarovalnica pisna obvestila zavarovalcu (tudi zavarovancu) pošilja na naslov, ki ga navede ob sklenitvi pogodbe.

(2) Zavarovalec oziroma zavarovanec mora zavarovalnico

obvestiti o spremembi svojega bivališča oziroma sedeža ali svojega imena oziroma imena podjetja v 15 dneh od dneva spremembe.

(3) Če poskus vročitve pošiljke s priporočeno poštno pošiljko na naslov, ki ga je zavarovalec navedel ob sklenitvi pogodbe, oziroma na naslov, ki ga je zavarovalec zavarovalnici sporočil med trajanjem pogodbe, ali na naslov stalnega prebivališča zavarovalca, kot je naveden v Centralnem registru prebivalstva oziroma na poslovni naslov podjetja, kot je naveden v Poslovnem registru Slovenije, ni bil uspešen (npr. ker zavarovalec ni prevzel poštne pošiljke oziroma je odklonil njen sprejem), šteje, da je bila pošiljka vročena s potekom 15-dnevnega roka, v katerem bi lahko zavarovalec priporočeno poštno pošiljko prevzel na poštnem uradu. Zavarovalec mora zavarovalnico takoj, ko izve za fikcijo vročitve pošiljke, obvestiti, če pošiljke ni mogel prevzeti iz razlogov, ki niso bili na njegovi strani. V tem primeru šteje, da mu je bila pošiljka vročena, ko zavarovalnica prejme njegov pisni ugovor, v katerem zavarovalec pojasni vse okoliščine primera in priloži dokaze, ki opravičujejo dejstvo, da priporočene pošiljke ni prevzel v danem 15-dnevnem roku, in da tega ni mogel storiti nihče drug po njegovem pisnem pooblastilu.

(4) Pravna fikcija uspele vročitve, navedena v prejšnjem odstavku, ima na podlagi pogodbenega dogovora z zavarovalcem pravno veljavne učinke.

19. člen – PREPREČEVANJE KORUPCIJE

Pogodba, pri kateri kdo v imenu ali na račun druge pogodbene stranke, predstavniku ali posredniku organa ali organizacije iz javnega sektorja obljubi, ponudi ali da kakšno nedovoljeno korist za pridobitev posla ali za sklenitev posla pod ugodnejšimi pogoji ali za opustitev dolžnega nadzora nad izvajanjem pogodbenih obveznosti ali za drugo ravnanje ali opustitev, s katerim je organu ali organizaciji iz javnega sektorja povzročena škoda ali je omogočena pridobitev nedovoljene koristi predstavniku organa, posredniku organa ali organizacije iz javnega sektorja, drugi pogodbeni stranki ali njenemu predstavniku, zastopniku, posredniku, je nična.

20. člen – SANKCIJSKA KLAVZULA

(1) Zavarovalnica ne zagotavlja zavarovalnega kritja in nima obveznosti poplačila zahtevka ali plačila kakršne koli druge koristi v primeru, če bi takšno poplačilo zahtevka ali plačilo kakršne koli druge koristi izpostavilo zavarovalnico kakršnim koli sankcijam, prepovedim, omejitvam, kontrolam izvoza in/ali uporabe menjalnih tečajev na podlagi resolucij Združenih narodov ali trgovinskim ali ekonomskim sankcijam, kršitvam zakonov ali predpisov Evropske unije, Združenih držav Amerike, Združenega kraljestva, Republike Slovenije ali predpisov katere koli jurisdikcije, ki velja za zavarovalnico.

(2) Zavarovalnica ne zagotavlja zavarovalnega kritja in nima obveznosti poplačila zahtevka ali plačila kakršne koli druge koristi v povezavi z izgubami, škodo ali obveznostmi, ki izhajajo iz dejavnosti v sankcioniranih državah/ozemljih, ali iz dejavnosti, ki so neposredno ali posredno povezane z ali koristijo njihovim vladam, osebam ali subjektom s prebivališčem v sankcioniranih državah/ozemljih, ali osebam ali subjektom v sankcioniranih državah/ozemljih ali njihovih teritorialnih vodah. Ta izključitev se ne uporablja za dejavnosti, ki se izvajajo, ali storitve, ki se opravljajo v izrednih razmerah zaradi varnosti, ali kadar je bila o tem tveganju zavarovalnica obveščena ter je pisno potrdila zavarovalno kritje.

(3) Za sankcionirane države/ozemlja po prejšnjem odstavku štejejo Krim, Demokratična ljudska republika Koreja, Iran, Sirija in Venezuela, pri čemer se seznam teh držav lahko spremeni. Vsakokrat veljavni seznam teh držav je dostopen na www.generali.si/sankcijska_klavzula.

21. člen – INFORMACIJA O OBDELAVI OSEBNIH PODATKOV

(1) Zavarovalnica spoštuje pravico do zasebnosti svojih strank. V ta namen je zavarovalnica pripravila celovito »Informacijo o obdelavi osebnih podatkov«, ki je dostopna na www.generali.si/vop. Informacija se lahko zahteva tudi v pisni obliki prek brezplačne telefonske številke **080 70 77** ali pooblaščenega zastopnika zavarovalnice.

(2) Zavarovanec pooblašča zavarovalnico in asistenčni center, da v njegovem imenu pridobi in vpogleda v zdravstveno dokumentacijo ter drugo dokumentacijo, ki je potrebna za ugotavljanje okoliščin sklenitve zavarovanja in pri ugotavljanju obveznosti zavarovalnice.

22. člen – IZVENSODNO REŠEVANJE SPOROV

Če zavarovalec, zavarovanec ali drug upravičenec s storitvijo zavarovalnice ni zadovoljen, lahko o tem obvesti zavarovalnico. Potrošniki imajo zoper odgovor zavarovalnice oziroma odločitev pritožbene komisije zavarovalnice pravico vložiti pobudo za začetek postopka mediacije pred izbranim izvajalcem izvensodnega reševanja potrošniških sporov, tj. Mediacijski center pri Slovenskem zavarovalnem združenju, Železna cesta 14, SI-1000 Ljubljana, telefon: +386 (0)1 300 93 81, elektronski naslov: irps@zav-zdruzenje.si, spletno mesto: www.zav-zdruzenje.si. Več informacij o pritožbenih postopkih je na voljo na www.generali.si/pritozbeni-postopki ali prek telefona **080 70 77**.

23. člen - KONČNA DOLOČILA

(1) Za razmerja iz zavarovalne pogodbe se uporablja slovensko pravo.

(2) Za izvajanje nadzora nad zavarovalnico je pristojna Agencija za zavarovalni nadzor, Trg republike 3, Ljubljana.

(3) Poročilo o solventnosti in finančnem položaju zavarovalnice je dostopno na www.generali.si.

(4) Ti pogoji so veljavni od 03.01.2020 naprej.

PREGLEDNICA ZAVAROVALNIH KRITIJ ZA TUJINA

Zavarovalna kritja TUJINA veljajo glede na izbran paket (TUJINA ali TUJINA PLUS) in glede na izbrano kombinacijo.

ZAVAROVALNA KRITJA		TUJINA			TUJINA PLUS		
		Kombinacija A	Kombinacija B	Kombinacija C	Kombinacija A	Kombinacija B	Kombinacija C
Skupaj za vsa zavarovalna kritja največ do zavarovalne vsote (na osebo):		**25.000 EUR** 20.000 EUR* 1.000 EUR **	**50.000 EUR** 40.000 EUR* 2.000 EUR**	**100.000 EUR** 60.000 EUR* 3.000 EUR**	**25.000 EUR** 1.000 EUR **	**50.000 EUR** 2.000 EUR **	**100.000 EUR** 3.000 EUR **
1.	Medicinska oskrba in obisk zdravnika	√	√	√	√	√	√
2.	Zdravljenje	√	√	√	√	√	√
3.	Zdravila in zdravniški pripomočki	√	√	√	√	√	√
4.	Nujne zobozdravstvene storitve	100 EUR	200 EUR	300 EUR	100 EUR	200 EUR	300 EUR
5.	Prevoz do najbližje bolnišnice ali klinike in nazaj	√	√	√	√	√	√
6.	Prevoz v domovino	√	√	√	√	√	√
7.	Prevoz in bivanje za osebo, ki ostane v spremstvu zavarovanca	√	√	√	√	√	√
8.	Spremstvo in prevoz mladoletnega otroka	√	√	√	√	√	√
9.	Prevoz družinskega člana	vozovnica	vozovnica	vozovnica	vozovnica	vozovnica	vozovnica
10.	Prevoz posmrtnih ostankov v domovino zavarovanca	√	√	√	√	√	√
11.	Vrnitev v domovino	√	√	√	√	√	√
12.	Preklic leta				100 EUR	150 EUR	250 EUR
13.	Izguba/kraja prtljage				300 EUR	500 EUR	800 EUR
14.	Zamuda prtljage/leta				100 EUR	150 EUR	200 EUR
15.	Izguba/kraja osebnih dokumentov				100 EUR	150 EUR	200 EUR
16.	Predujem varščine				2.000 EUR	4.000 EUR	6.000 EUR
17.	Nujno nakazilo denarja				2.000 EUR	3.000 EUR	4.000 EUR
18.	Organizacija storitev ob spremembi bivanja v tujini				√	√	√
	Starostna omejitev				75 let		
	Starostna omejitev (potrebna dodatna premija)				85 let		
	Starostna omejitev (potrebna dodatna premija)				nad 85 let		
	Geografska veljavnost				cel svet		
	√ - vključeno						

* Velja za zavarovanje oseb s stalnim bivališčem v tujini, ki začasno bivajo in delajo v RS.
** V primeru akutnega poslabšanja kronične bolezni so vsa zavarovalna kritja ne glede na izbrano zavarovalno vsoto skupaj omejena do navedenega zneska.

GENERALI zavarovalnica d.d., Kržičeva ulica 3, 1000 Ljubljana | Matična številka: 5186684000 | ID za DDV:88725324 I Okrožno sodišče v Ljubljani I
Osnovni kapital 39.520.347,18 EUR I Družba pripada zavarovalniški skupini Generali Group.

GENERAL TERMS AND CONDITIONS "TUJINA" 01-TUJ-01/20

TRANSLATION: Only the Slovene version shall be legally binding.

Insurance General Terms and Conditions with Assistance abroad "Tujina" (hereinafter: the Terms and Conditions) are an integral part of the Insurance Contract, stipulated between the Policyholder and the Insurance Company.

THE TERMINOLOGY IN THE PRESENT TERMS AND CONDITIONS MEAN THE FOLLOWING:

Policyholder - The person stipulating the Contract with the Insurance Company and who is supposed to pay the Premium.
Insured Party - The person whose property interests is insured. The Policyholder and the Insured Party are the same person, except in the case of insurance on behalf of third party or on behalf of a person insured by such an insurance.
Insurance Company - GENERALI zavarovalnica d.d., Kržičeva ulica 3, Ljubljana.
Beneficiary - The person entitled to receive the benefit or cost reimbursement upon occurrence of an Insured Event.
Policy - A document proving the conclusion of the Contract.
Contract - Insurance contract stipulated between the Policyholder and the Insurance Company.
Premium - A sum, which must be paid to the Insurance Company under the Contract by the Policyholder.
Benefit - A sum paid by the Insurance Company under the provisions of the Contract.
Insured Sum - A sum that represents the upper limit of the liability of the Insurance Company at the time of the occurrence of the Insured Event.
Deductible - Agreed participation of the Insured Party in the Insured Event.
Insured Event - A loss event covered by Insurance Company, which must be future, uncertain and independent of the exclusive will of the contractors and it creates an obligation of the Insurance Company.
Assistance - Aid offered to the Insured Party who find themselves in trouble while being in Other countries.
Assistance Centre - The Insurance Company`s assistance call centre that organising and implementing assistance that must be contacted at the telephone number indicated on the Policy in the case the Insured Event or if Assistance is needed to use the services under the Contract.
Other countries - An area where the Insurance Company offers insurance covers to the Insured Party in accordance with the Contract. The Home country is not considered as Other countries.
Home country - The country of the Insured Party`s permanent address. If the Insured Party has no permanent address, their temporary address shall apply.

1. ARTICLE – INSURED RISKS

(1) The Insurance offers the following insurance coverage, which depends on the selected package listed in the Coverage Table at the end of these Terms and Conditions:

1. ASSISTANCE SERVICES:
- the availability of the Assistance Centre 24/7;
- the organisation of urgent medical aid;
- the organisation of urgent medical transportation for the Insured Party;
- providing information for the Insured Party and their closest family members;
- telephone costs for urgent calls to the Assistance Centre.

2. EXPENSES:

2.1 Medical care and doctor's visit
The costs of urgent medical care and doctor's visits resulting from an accident or illness of the Insured Party abroad are covered.

2.2 Treatment
The costs of urgent treatment resulting from an accident or illness of the Insured Party abroad are covered. The costs are covered up to the day when the Insured Party's medical conditions allows for transportation to their Home country to continue treatment there. The costs of urgent treatment covers also costs of treatment for acute deterioration, but only for the following chronic diseases: cardiac diseases, kidney stones, gallstones, asthma and diabetes. The cost of treatment of acute deterioration of chronic diseases is limited – the restrictions are stated in the Coverage Table at the end of these Terms and Conditions.

2.3 Medicinal products and medical devices
The costs of medicinal products and medical devices in the event of an urgent medical treatment are included, issued on prescription or prescribed in the medical report.

2.4 Urgent dental treatment
The insurance covers the costs of urgent dental treatment necessary for the elimination of acute pain resulting from an illness or recent dental injury, including tooth extraction.

3. ADDITIONAL COSTS:

3.1 Transportation to the nearest hospital and back
The costs of transportation of the Insured Party to the nearest hospital or clinic back to the place of accommodation abroad are included.

3.2 Transportation to Home country
The costs of transportation of the Insured Party to the Home country are included, if the medical condition of the Insured Party allows for the transportation, two conditions being required for this insurance cover, namely the approval of the Assistance Centre, and that the Insured Party is prevented from returning to the Home country in the manner planned due to their medical condition.

3.3 Transportation and accommodation for the person that accompanies the Insured Party
Additional costs of transportation and accommodation for the person staying at the request or the recommendation by the treating physician that accompanies the Insured Party, or the costs of transportation of a close relative from home to the location of hospitalisation, if the Insured Party may not be accompanied otherwise. In the case of a minor child, additional costs of transportation and accommodation for the person that accompanies the Insured Party are covered, and no recommendation by the treating physician is required.

3.4 Attendance and transportation of a minor
Costs of transportation of the Insured Party's child (a minor) to their Home country are covered, as well as costs of transportation of the person accompanying him/her if the Insured Party is hospitalised or has died, and the child remains without the attendance of an adult person.

3.5 Transportation of a family member
Costs of visiting the Insured Party are covered. Costs include the cost of public transportation (economy class) for one family member (child, spouse, parent, brother or sister, spouse's parent), if the Insured Party is alone abroad and is unable to return home for medical reasons, and is hospitalised more than 7 days due to reasons covered by these Terms and Conditions. Costs for a taxi are also covered, if a person decides to use taxi instead of general transportation services, however only to the amount of the public transportation ticket (bus or train).

3.6 Transportation of mortal remains to the Insured Party's Home country
Costs for transportation of the Insured Party's mortal remains to the Home country are covered.

3.7 Return to Home country
Costs of organisation of an urgent early return to the Home country in the event of severe illness or death of a close relative (child, spouse, parent, brother or sister, spouse's parent). Costs of

changing a flight ticket or costs of regular return flight (economy class), if it is impossible to change a flight or take a train (1st class).

Costs stated in Items 3.3 to 3.5 of this Paragraph are not reimbursed without a prior consent given by the Assistance Centre.

4. ADDITIONAL COVERAGE:

4.1 Flight cancellation

If the flight cancellation and waiting for the next flight takes more than 6 hours, the costs arising after that time are covered for the following: accommodation and transportation to the nearest accommodation facility at the airport where the flight was cancelled, a restaurant meal and beverages, but only upon submission of original invoices incurred between the originally scheduled flight departure and the actual departure of the flight.

4.2 Loss/theft of luggage

a) If during the stay of the Insured Party their luggage is lost or stolen, the Insured Party is entitled to benefit as a compensation for the damage incurred. In order to receive benefit, the Insured Party must provide an accurate description of the luggage together with the date of purchase and value. The amount of benefit depends on the value of the luggage, proven with invoices or based on the prices valid on the day of the occurrence of the Insured Event, as well as on the age and wear of the luggage, taking into account the following:
   - luggage, up to 6-months old – 100% payout based on demonstrated value, but to the maximum amount as stated in the Coverage Table at the end of these Terms and Conditions;
   - luggage, from 6-months to 1-year-old – 80% payout based on demonstrated value, but to the maximum amount as stated in the Coverage Table at the end of these Terms and Conditions.
     The payout reduces for additional 10% for every consequent year commenced.
     In the payout for portable mobile devices (telephones, tablets, etc.), the amount actually paid by the Insured Party for the portable mobile device (various campaigns, subscriptions, etc. apply) is taken into account.

b) Luggage is considered to be items for personal use which the Insured Party has with him/her abroad, under constant supervision, and which were to the Insured party:
   - misappropriated (theft/robbery), but only if the event is reported to the local police in the place (country) of occurrence of the event within 24 hours at the latest and the Insured Party submits a police record thereof;
   - lost during transport for which a third party is responsible, but only upon presentation of the airline's certificate that the luggage is definitively lost and the search is completed.

4.3 Delay in luggage/flight

If the luggage/flight of the Insured party is delayed more than 4 hours, the costs incurred after that time are covered, in the case of:

a) if the delay of a flight occurs abroad, the costs for the restaurant meal and beverages incurred between the originally scheduled flight departure and the actual departure of the flight are covered, but only upon submission of the original invoices, and the airline's confirmation of the number of hours delayed and the cause of the delay;

b) if luggage is delayed, the cost of purchasing essential clothing/footwear, medicinal products and toiletries is covered, but only upon submission of the original invoices, and the airline's confirmation of the number of hours delayed and the cause of the delay, only the luggage is delayed abroad.

4.4 Loss/theft of identity documents

If the Insured Party loses or has been misappropriated (theft/robbery) of the official identity documents, which are required for the return trip (travel and/or identity document), the cost of producing the new official personal identification documents will be covered. In the event of theft of identity documents, the Insured Party must report the incident to the local police in the place (country) of the event.

4.5 Bail advance payment

If the Insured Party is obliged to pay the local authorities a bail, the Insurance Company will pledge the bail on their behalf, but up to the amount indicated in the Coverage Table at the end of these Terms and Conditions. The Insured Party must sign a commitment for the payment of this amount before the bail is paid. The Insured Party is obliged to reimburse this amount within 15 days after receiving the invoice from the Insurance Company.

4.6 Urgent money transfer

If an Insured Party sends a request for assistance to the Assistance Centre for an event covered by these Terms and Condition, he/she is required to pay other unforeseen expenses. The Insurance Company will, upon their request, transfer the requested amount of money in local currency, up to a maximum amount as set out in the Coverage Table at the end of these Terms and Conditions. The Insured Party must sign a commitment for the payment of this amount before the money transfer. The Insured Party is obliged to reimburse this amount within 15 days after receiving the invoice from the Insurance Company.

4.7 Organisation of services upon changes when staying abroad

If the occurrence of an Insured Event under these Terms and Conditions requires that the Insured Party has to prolong, shorten or change their location during their stay abroad, the Assistance Centre will organise the reservation services and carry forward all the necessary messages. All urgent messages will be carried forward to the family of the Insured Party or to the desired job address. The Assistance Centre will also adjust hotel and airline bookings, car rental bookings, etc.

(2) Only services which are strictly necessary for the maintenance of vital functions or for the prevention of serious deterioration of the health status of a terminally ill or injured Insured Party shall be considered as emergency services.

(3) The total amount of expenses per person, including the medically justified costs referred to in Paragraph 1 of this Article, for all Insured Events that occur during the validity of the health insurance shall not exceed the amount of the sum insured in the Coverage Table listed at the end of these Terms and Conditions. Notwithstanding the foregoing, the insurance cover for treatment costs for acute deteriorations of chronic diseases and urgent dental treatment is limited and is only provided up to the amount shown in the Coverage Table at the end of these Terms and Conditions. In the case of acute deteriorations of chronic diseases and urgent dental treatment, this limitation applies to all insurance coverage under these Terms and Conditions, so in such cases the amount of benefit can only be up to the limited sum.

(4) When the entire sum insured for individual coverage from individual Policy has been paid out, this insurance coverage shall cease.

(5) The Insurance Company and the Assistance Centre shall not be liable in any way for the actions of the service providers,

which are organised and paid under the insurance coverage under these Terms and conditions. The responsibility of the Insurance Company or the Assistance Centre for any poor performance of works or services by individual contractors is excluded.

(6) The Insured Party must take great care to prevent loss, damage, accident, injury or illness. It must also safeguard, keep and/or locate their property and, to the best of their ability, limit costs.

2. ARTICLE – INSURED PARTIES

(1) In individual insurance, the Insured Party is the person indicated in the insurance policy.

(2) In family insurance, all persons indicated in the policy living together and being inter-related are the Insured Party: spouse or partner from any legally recognised domestic partnership, and their children, stepchildren, foster children or adopted children up to the age of 26.

(3) In group insurance, all persons indicated in the policy or in the attachment of the policy are the Insured Parties, and represent a group. A group is 9 or more persons who are leaving together to the same destination abroad. If fewer than 9 persons are insured as a group, the provisions for individual insurance shall apply, unless specified otherwise.

(4) Under these Terms and Conditions, only persons up to 75 years of age may be insured parties. Persons aged 75 years or more can be insured by paying an extra Premium.

3. ARTICLE – EXCLUSIONS

(1) All the obligations of the Insurance Company are excluded with events arising as consequences of the following:

1. earthquake;
2. active service of the Insured Party in the Armed Forces;
3. active participation of the Insured Party in war (declared or not declared), invasion, foreign enemy action, hostility, civil war, terrorism, rebellion, riot, revolution, public meeting, rally or insurrection;
4. the suicide or attempted suicide of the Insured Party;
5. events that are in any way related to conscious self-harm or illness, senseless conduct, events that occur when the Insured Party is under the influence of alcohol or drugs or other illicit substances, or events where the Insured Party is unnecessarily exposed to danger (except in an attempt to save a human life);
6. driving of the Insured Party with motor and other vehicles without appropriate official permits (driver's licence, registration certificate);
7. intentional or intentional crime by the Insured Party;
8. events related to any contribution to the use, release or threat of any nuclear weapons or devices, chemical or biological substances, as well as to events that are in any way caused or contributed to by acts of war, resistance, uprising or unrest;
9. radioactive radiation, epidemics, pandemics.

(2) Nor does insurance provide assistance services or cover any costs in connection with events resulting from:

1. preparation of or participation in:
   - motor racing sports competitions, racing or racecourses or participation in training and for recreational purposes;
   - sports aviation, parachuting, paragliding, gliding;
   - alpinism;
   - caving;
2. recreational purposes (unless a specific activity is specifically agreed and derived from the policy):
   - mountaineering and trekking at the altitude higher than 3,000m above sea level;
   - diving and underwater fishing;
   - kite surfing, kite boarding;
   - skiing and boarding outside marked skiing slopes or heliskiing;
   - free climbing;
   - downhill, all mountain, enduro, etc.;
   - in other sports competitions and training;
3. the pursuit of extreme sports or where they are directly related to a particularly dangerous activity that is associated with a hazard far exceeding the normal risk of being abroad;
4. expeditions to unknown and unexplored areas;
5. phone costs, apart from emergency calls to the Assistance Centre;
6. losses or events not expressly stated in these Terms and Conditions to be covered by the insurance coverage;
7. personal injury, illness, death, loss, expense, or any other obligation associated with HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome) or any similar syndrome, whatever its name, except if the Insured Party becomes infected during a medical examination, trial or treatment (but only if this is not related to drug use or STDs).

(3) The Insurance Company does not cover costs in the following events:

1. if, at the request of the Insurance Company, the Insured Party does not allow to be examined by a physician appointed by the Insurance Company or its representatives;
2. services provided by any contractor other than the contractual partner of the Insurance Company or the Insurance Company did not vouch for it, and services performed without the authorisation and/or participation or approval of the Assistance Centre;
3. if they are the result of any air transport by the Insured Party, unless he/she was travelling as a passenger who paid the fare;
4. if they are due to the fact that the Insured Party did not take due care to prevent the loss, damage, accident, personal injury or illness of himself/herself or their property;
5. which the Insured Party would have had to pay even if the incident in which the Assistance Centre intervened had not occurred.

(4) All obligations of the Insurance Company in case of giving false information of the Policyholder or Insured Party regarding the duration of the stay abroad, the circumstances of the event, the injury or the type of illness, and any fraud or forgery are excluded.

(5) An Insurance Company cannot be required to provide a service to the Insured Party when he/she is located in an area where there is a risk of war, political or other circumstances that would make such services impossible or justifiably impracticable.

(6) All obligations of the Insurance Company are excluded in case the Insured Party does not follow the instructions given to him/her by the Assistance Centre.

(7) If, when they find themselves in trouble, the insured parties do not call the Assistance Centre, it is considered that the insurance case has not arisen under these Terms and Conditions, and in this case the Insurance Company is not obliged to reimburse any costs.

4. ARTICLE – SPECIFIC EXCLUSIONS

(1) In addition to the general exclusions referred to in Article 3, these Terms and Conditions shall also apply to insurance coverage related to Treatment, Medicines and Medical Devices, Urgent Dental Services, and Transportation Home, as well as the following specific exclusions relating to the following treatments, items, conditions, activities, and associated and resulting costs:

1. claims related to the effects of alcohol consumption, drug use, etc. If these facts are established subsequently, the Insurance Company reserves the right of recourse for all costs already paid on the basis of such claims;
2. deteriorations of pre-existing or recurrent illnesses that have caused the Insured Party to be treated or have appeared and have not been completely eliminated before the commencement of the insurance or before going abroad, and all chronic diseases and conditions, except those mentioned in Item 2.2, Paragraph 1, Article 1 of these Terms and Conditions;
3. recurring sprains and dislocations, and treatment of

injuries that occurred before the commencement of the insurance or before going abroad;
4. dental services, with the exception of urgent dental services, which are required to eliminate acute pain resulting from an illness or recent dental injury, including tooth extraction, to the sum stated in the Coverage Table at the end of these Terms and Conditions;
5. transportation for issues, which may be treated at the location;
6. treatment which may be offered by the person who accompanies the Insured Party;
7. treatment offered by the person/physician who accidentally finds himself/herself at the location before the arrival of a competent physician;
8. sexually transmitted diseases (STDs);
9. pregnancy, regular examinations during pregnancy, typical issues during pregnancy, labour after 37 weeks of gestational age, except in the case of saving the life of the mother or the child;
10. planned termination of pregnancy;
11. special hospital services – above-standard, such as single-bed room, TV, special accommodation, etc.;
12. treatment or surgery that can be postponed without any consequences for you to the time after your return to your Home country;
13. claims arising after returning to Home country;
14. the cost of optical aids unless they are incurred as a result of a medical emergency;
15. treatment performed by a doctor without an officially recognised authorisation;
16. costs incurred as a result of treatment not confirmed by a medical report;
17. transport costs if, according to the attending physician, the Insured Party is medically fit to return to their Home country in the originally planned manner;
18. accidents at work or any other activity requiring increased physical effort, unless specifically agreed in the policy;
19. mental or behavioural disorders;
20. events occurring while going abroad, to which the Insured Party goes in contravention of medical advice;
21. events related to cosmetic surgeries unless surgery is necessary because of an acute illness or defect covered by this insurance;
22. preventive regular vaccinations.

(2) In addition to the exclusions referred to in Article 3, these Terms and Conditions shall also apply to insurance coverage related to Flight cancellation, Loss/theft of luggage, Delayed luggage/flight and Loss/theft of identity documents relating to the following items, conditions, activities, and associated and resulting costs (and associated and resulting costs):

1. vehicle or boat fittings, loss or theft of motor vehicles, air and water vehicles, as well as all appertaining accessories, gliders, kites, parachutes and ice boats for ice yachting;
2. items left unattended in a place that is publicly accessible and has been deposited, pledged, lost, forgotten or dropped by the Insured Party;
3. loss or theft not reported to the police, the airline, the shipping line or their agent within 24 hours of the detection and receipt of the written report;
4. loss resulting from confiscation or detention at customs or by other authorities;
5. theft of items from unsupervised vehicles, unless they are in a locked luggage compartment which must be separate from the passenger compartment or, if the vehicle does not have a luggage compartment, in a locked vehicle and in a location which is not visible from the outside, provided that the vehicle is parked in a secured a parking space or a locked garage and, if police records show that there was a break-in of that vehicle;
6. theft of items in the vehicle as a consequence of theft of that vehicle;
7. claims for loss or theft from a residence, unless there is evidence of violent breaking and entering, which is also confirmed by a police report;
8. mobile phone, camera, photographic equipment (tripods, lenses, etc.), camera, MP3 player and laptop, unless the Insured Party has been misappropriated with robbery or stealing by force;
9. money, checks, credit/debit cards, securities, tickets, valuables and jewellery, unless stored in a hotel safe or in a locked room safe;
10. loss of contact lenses, glasses, hearing aids, dental or other prosthetics, cosmetics, antiques, musical instruments, manuscripts, perishable goods, animals and bicycles;
11. loss of property that the Insured Party has borrowed, rented or leased;
12. loss or theft of objects or accessories required for the pursuit of a professional activity, motor equipment and other objects used by the Insured Party in connection with their business activity, craft, profession or job;
13. loss or theft of sports equipment or sportswear during their use;
14. currency or financial deficit devaluations due to errors or omissions during a bank transaction;
15. the cost of picking up delayed luggage;
16. the cost of delayed luggage when returning or returning to Home country;
17. payments for the first 4 hours of delayed flights;
18. payments for the first 6 hours of the flight cancellation;
19. delays due to the fact that the Insured Party did not arrive at the place of departure in due time given circumstances known to him/her at that time;
20. delays due to the fact that the Insured Party did not submit the required documents;
21. delays resulting from the suspension or cancellation of service by any official body or as a result of a strike;
22. costs reimbursed by the airline.

5. ARTICLE – EXCLUSIONS OF ACTS OF TERRORISM

(1) Notwithstanding the other provisions of the Contract, this insurance shall not cover damage caused directly or indirectly by the act of terrorism, nor any costs incurred as a result of such damage, even if combined with the act of terrorism, if the cause of the damage was influenced by another cause or action.

(2) A terrorist act is any act of violence or an act which endangers human life or movable or immovable property or infrastructure using force, violence or threatening, is performed due to political, religious, ideological or similar reasons and has the purpose of influencing or influences the government of a country or has the purpose of intimidating or intimidates the public or any part of it, or has such an effect. Both acts which are performed independently and acts which are performed in cooperation with any organisation or authority are considered to be terrorist acts.

(3) Damage and costs incurred due to preventing or suppressing terrorist acts are also excluded from coverage.

6. ARTICLE – AREA OF INSURANCE

The insurance coverage is applicable only abroad.

7. ARTICLE – VALIDITY OF INSURANCE

(1) The Contract is concluded when the contracting parties sign the policy or the coverage certificate.

(2) The Insurance Company is only liable if there is a loss event after the beginning and before the end of the insurance coverage. Unless otherwise agreed, the obligation of the Insurance Company shall commence on the day indicated in the policy as the commencement of the insurance, provided that the Premium has been paid by then, or else it shall commence on the day following the day on which the Premium has been paid. The obligation of the Insurance Company ends on the day stated as the end of the insurance in the insurance policy.

(3) If it is agreed that the Premium should be paid:

1) at the conclusion of the Contract and the Premium has not been paid, the obligation of the Insurance Company to pay the contractual insurance or indemnity agreed in the Contract begins the next day

after the Premium has been paid;

2) after the conclusion of the Contract, the obligation of the Insurance Company to pay the contractually determined payout or damages starts on the day that is stated in the Contract as the beginning date of the insurance.

(4) If the duration of the insurance is not determined in the Contract, or if the duration of the insurance is determined in the Contract and provides the possibility of extending the Contract for the same time period, each of the Contracting Parties can rescind the contract on the day that the Premium is due, provided that it notifies the other Contracting Party of it in writing no less than 3 months before the Premium is due.

(5) If the insurance is arranged for more than three years, each party may rescind the Contract with a six months' written notice.

(6) If a discount in relation to the agreed Premium of the insurance has been applied, and if the insurance ended before this time period, the Insurance Company is entitled to require the Policyholder to pay the difference up to the Premium that the Policyholder should have paid if the Contract had only been concluded for the period of time during which it actually lasted. If a Premium discount has been recognised on the basis of several contracts stipulated with the Insurance Company (package discount), in case of termination of one or all of these contracts (whatever the reason), the Insurance Company may reduce or cancel the package discount accordingly, and the Policyholder must pay the corresponding Premium.

(7) If the Contract is terminated by the Insurance Company, it may offer, together with the termination, the Policyholder to conclude a new similar Contract. The Policyholder is entitled to notify the Insurance Company that he/she does not agree with the conclusion of a new Contract within 30 days of receiving the termination and the offer for concluding a new Contract. In this case, the insurance relationship ends at the end of the current insurance year. If the Policyholder does not notify the Insurance Company of anything upon receiving the termination and the offer for concluding a new Contract, it is considered that the Policyholder's requirements had not changed and that the Policyholder agrees with the offer for the conclusion of a new Contract, and the insurance relationship continues in line with the new Contract at the end of the current insurance year. Based on the conclusion of the new Contract, the Insurance Company will send a new policy to the Policyholder.

(8) In the case of out insurance at a distance, the Contract is concluded with the payment of a Premium, which the Policyholder proves with a certificate of payment of the Premium. The Policyholder as a consumer is entitled to cancel the Contract by submitting to the Insurance Company a written notice within 14 without having to give a reason for their decision. In this case, the Insurance Company is entitled to retain the Premium for each day it provided insurance coverage. The withdrawal must be in writing and filed with the Insurance Company before the deadline, where the withdrawal is filed before the deadline if it has been sent by registered mail before the deadline. If the insurance is concluded at a distance for a period of less than one month, it is not possible to terminate the Contract.

(9) The all-year-round insurance for several trips abroad applies to an unlimited number of trips abroad within the year of insurance, whereby each individual trip may last 90 days, at a maximum.

(10) The insurance must be taken out before the Insured Party goes abroad. If the Insured Party is abroad when the policy is taken out, the insurance coverage under these Terms and Conditions shall take effect only 5 days after the day stated on the policy as the beginning of the insurance.

(11) The Policyholder may terminate the Contract at a time when the insurance cover has not yet arisen – prior to the commencement of the insurance as indicated in the policy.

(12) Cancellation is not possible after insurance coverage begins, except in the case of distance contracting.

8. ARTICLE – PREMIUM PAYMENT AND CONSEQUENCES OF A DEFAULT IN PREMIUM PAYMENT

(1) The Premium or the first instalment must be paid by the Policyholder upon taking out the insurance. Payment made at the conclusion of the Contract shall also be considered a payment made no later than the due date specified on the receivable document. In this case, the insurance cover is provided from the day and time specified as the beginning of the insurance. If the Premium (or the first instalment) has not been paid in full by the due date on the receivable document, the insurance cover is guaranteed only the next day after the full payment.

(2) The premiums for the following insurance years (or the first instalment in the following insurance year) for multi-annual insurance must be paid by the Policyholder on the first day of each subsequent insurance year. Unless otherwise agreed, the payment dynamics for the following insurance years shall be the same as for the first insurance year.

(3) If it is agreed that the Premium is paid in instalments or subsequently, an additional payment can be charged. If the instalment has not been paid by the day it is due, the Insurance Company is entitled to require the payment of statutory interest rate and immediate payment of all instalments not yet due.

(4) If the Premium was paid at a post office or in the bank, the date of payment is considered to be the date when the payment order was submitted to the post office or to the bank. Unless an exact reference is made at the time of payment of the Premium in order to indicate which Premium or what instalment of the Premium, and under which Contract is being paid, the unpaid Premium or the instalment of the Premium, which is the oldest after the due date shall be considered paid, regardless of the type of Contract concluded with the Insurance Company.

(5) In case of the termination of the Contract due to the unpaid due Premium, the Policyholder must pay the Premium for the period until the day of the termination of the Contract. If an Insured Event occurred up to the day of the termination of the validity of the Contract, for which the Insurance Company must pay the damages or policy proceeds, the Policyholder must pay the complete Premium for the current policy year. Furthermore, the Policyholder must also reimburse the Premium discount applied for the agreed upon insurance period, in accordance with the Paragraph 6 of Article 7 of these Terms and Conditions.

(6) In case of any insurance payout, the Insurance Company is entitled to deduct all unpaid due premiums of the previous insurance year or compensations, as well as other outstanding obligations of the Policyholder towards the Insurance Company from previous years, from the insurance indemnity.

(7) The obligation of the Insurance Company to pay policy proceeds or damages is not applicable if the Policyholder does not pay the Premium before the due date that is due after the conclusion of the Contract, nor if another interested party does it within 30 days from the receipt of a registered letter from the Insurance Company with the note that the Premium is due, whereas the aforementioned deadline cannot be shorter than 30 days after the Premium is due.

(8) After the deadline set in the Paragraph 7 of this Article and if the payment of the Premium that has to be paid upon the conclusion of the Contract or other of the following premiums is overdue, the Contract is terminated without a notice period, whereas the termination of the Contract shall take place after the deadline from the paragraph 7 of this Article and after the termination of the insurance coverage, if the Policyholder was notified beforehand by registered mail containing a notice that the Premium is due and that the insurance coverage is terminated.

(9) In cases where the Insurance Company has not terminated the Insurance Contract, if the Policyholder pays the Premium after the expiry of the deadline as set in Paragraph 7 of this Article, but within one year from the maturity of the Premium, the Insurance Company shall be obliged to pay damages or policy proceeds from after 12am on the day of payment of the Premium and default interest. If the Policyholder does

not pay the Premium within this period, the Contract terminates at the end of the policy year.

(10) The Premium is charged with statutory duties (taxes, fees, etc.). If taxes are changed or new taxes are introduced (a new fee, a change in the tax rate, etc.) during the insurance period, these changes affect the amount of the agreed Premium.

(11) The Insurance Company charges the costs of paper-based operations and other administrative services in accordance with the price list published on www.generali.si/en.

(9) ARTICLE – REFUND OF PREMIUM

(1) In the event of termination of the Contract, the Insurance Company shall return the Premium paid.

(2) Whatever the reason for termination of the Contract, the Policyholder is entitled to claim a refund of Premium for the remaining duration of the insurance, only if no Insured Event has been reported for that insurance period. If the Insured Event was subsequently reported, the Policyholder must return the amount of the Premium to the Insurance Company at its request.

(3) The calculation of the refunded part of the Premium takes into account the administrative costs in accordance with the price list published at www.generali.si/ceniki.

(10) ARTICLE – RISK CIRCUMSTANCES

(1) Before the conclusion as well as during the term of the Contract the Policyholder has to report to the Insurance Company all circumstances that are important for the assessment of danger with which the Policyholder was familiar or should have been familiar. Circumstances that are important for the assessment of risk are taken into consideration, especially those circumstances with which the Policyholder is familiar and serve as the basis for the written Premium, as well as the circumstances stated in the Contract.

(2) The Policyholder is obliged to inform the Insurance Company of any change in circumstances that may be relevant to the hazard assessment. It shall also promptly inform the Insurance Company of an increase in the risk, if the risk has increased due to one of its actions, but if the increase has occurred without its cooperation, it must notify the Insurance Company within 14 days from the moment that it became aware of it. If the risk increase is such that the Insurance Company would not have concluded the Contract, if such a situation was the case at the time it was concluded, it may withdraw from the Contract. However, if the risk increase is such that the Insurance Company would only conclude a Contract for a higher Premium, if such a situation was the case at the time it was concluded, it may propose to the Policyholder a new amount of Premium. If the Policyholder does not give its consent to the new Premium within 14 days of receipt of such proposal, the Contract will be terminated by law. However, the Contract remains in force and the Insurance Company is no longer entitled to propose to the Policyholder a new Premium amount or to withdraw from the Contract if it does not exercise these rights within 30 days from the day it became aware of the increase in danger, or if before the expiry of that period it shows that it agrees to the Contract extension (if it accepts a Premium, it pays out the policy proceeds for the Insured Event arising after this increase, etc.).

(11) ARTICLE – OBLIGATIONS OF THE INSURED PARTY AFTER THE OCCURRENCE OF AN INSURED EVENT

(1) After an Insured Event occurs, the Insured Party must do everything within its power to prevent further damage occurring. In doing so, he/she must follow the instructions of the Assistance Centre and try to limit their expenses to the best of their ability.

(2) The Insured Party must notify the Assistance Centre about the occurrence of the loss event no later than three (3) days from the day he/she becomes familiar with it.

(3) The Insured Party must provide the Assistance Centre with all the information and other evidence available to him/her and which is strictly necessary for organising the Assistance, determining the cause, extent and amount of damage, and other additional documentation at the request of the Insurance Company. In any case, the Insured Party must follow the instructions given by the Assistance Centre or the Insurance Company. The Insured Party must keep all original invoices, certificates, official medical records justifying the necessity of treatment, tickets, contracts, toll payments, credit card payment invoices and any other supporting documents for submission at the request of the Assistance Centre or the Insurance Company.

(4) The Insured Party shall submit all certificates, information, approvals, official translations of the documentation and supporting documents required by the Assistance Centre or Insurance Company at their own expense. The Policyholder must complete and submit the form for the policy proceeds payment within thirty (30) days of the expense being incurred. This deadline may be extended subject to the prior approval of the Assistance Centre or the Insurance Company where supporting documentation is not available on time. All documents relating to the occurrence of the Insured Event must be in the original.

(5) If the Insured Party does not fulfil their obligations arising from this article in the agreed period, the Insurance Company can decline the payment of the insurance indemnity if, due to said failure to fulfil obligations, it cannot determine the cause of the occurrence of the Insured Event.

(6) If the Insured Party does not notify the Insurance Company of the Insured Event in the time and manner determined in these Terms and Conditions through their own fault, he/she must indemnify the Insurance Company for damages occurring thereafter.

(7) If the Insured Party has paid for the urgent health care services himself/herself, the Insurance Company shall reimburse the costs in accordance with Article 1 of these Terms and Conditions after submitting the required documentation, but only on condition that he/she has previously notified the Assistance Centre of the occurrence of the loss event.

(12) ARTICLE – OBLIGATIONS OF THE INSURANCE COMPANY

(1) Assistance services and costs covered under Article 1 of these Terms and Conditions shall be paid by the Insurance Company directly to the contractors.

(2) In the case when the Insured Party pays for urgent medical services or other expenses approved by the Assistance Centre himself/herself, the Insurance Company must return these costs as policy proceeds within 14 days, counting from the day when the Insurance Company has all the documentation based on which it is able decide on the basis and the height of the claim. If the amount of its liability is not established within this period, the Insurance Company must pay to the Insured Party or the Beneficiary at their request an undisputed part of its liability as an advance.

(3) The Insurance Company shall repay the amount paid at the reference rate of the European Central Bank (ECB) on the date of payment of the policy proceeds, but up to the amount in the Coverage Table at the end of these Terms and Conditions.

(4) The previous provision of this Article shall not apply if the Insured Party submits a proof showing the actual amount of costs in EUR at the date of occurrence of the Insured Event.

(5) The Insurance Company may offset the Policyholder's claim with the claim held by the Insurance Company against the Policyholder on whatever basis.

(13) ARTICLE – RIGHTS OF THE INSURANCE COMPANY

(1) In the case of an accident caused by a third party, the Insurance Company shall have the right to claim the reimbursement of the costs paid to the Insured Party, the Assistance Centre or the contractor from the person causing the accident.

(2) The Insurance Company reserves the right to reimbursement of all expenses incurred in the event that it is subsequently determined that the Insured Event was caused by the events referred to in Article 3 of these Terms and Conditions.

(14) ARTICLE – LIMITATION OF LIABILITIES DUE TO OTHER INSURANCES

If the Insured Party is insured under another Contract with another Insurance Company, the Insured Party is obliged to first assert their rights under another Contract. Under this Contract, the Insurance Company is only liable for payment if the other insurance company does not cover the damage to the Insured Party or is liable to pay the amount of the difference between the payment of the policy proceeds of the other Insurance Company and the damage calculated under this Contract.

(15) ARTICLE – EXPERT INVESTIGATION

(1) Each Contractual Party may request that certain disputed facts are established by experts.

(2) Each party shall name one of the experts, choosing from persons who are not employed by or related to the parties. The appointed experts shall, prior to the commencement of the work, appoint a third expert, who shall give their opinion only where the findings of the first two experts differ, and only within the limits of their findings.

(3) Each party shall bear the costs of the expert it names, and each party shall bear half of the costs for the third expert.

(4) Final conclusions are binding for both Contractual Parties.

(16) ARTICLE– CHANGE OF INSURANCE TERMS AND CONDITIONS OR PREMIUM RATES

(1) If the Insurance Company modifies the insurance Terms and Conditions or Premium rates, it must notify the Policyholder of the modification at least 60 days before the expiration of the current insurance year.

(2) The Policyholder has the right to terminate the insurance Contract in 30 days after the receipt of the notice. The Contract terminates when the current insurance year expires.

(3) If the Policyholder does not terminate the Contract, the Contract will be changed in accordance with the new insurance Terms and Conditions or the Premium rates starting next year.

(4) The Insurance Company may, within 30 days after finding out that inaccurate information (for example, the inadequacy of data on hazardous circumstances, data on the subject of insurance, data on previous loss events, customer data, etc.) have been provided to the policy and inform the Policyholder accordingly. If the Policyholder does not agree with the corrections, he/she may withdraw from the Contract within 14 days of receipt of the policy adjustments. If the Policyholder does not withdraw from the Contract within this period, it is considered that he/she agrees with these adjustments, therefore the Contract from the expiry of this period shall continue to be valid with the adjustments taken into account as arising from the adjustment of the policy.

(17) ARTICLE – MEANS OF NOTIFICATION

(1) The agreements on the content of an Contract apply only if in writing.

(2) All notifications and statements that must be given according to the provisions of the Contract must be written.

(3) A notice or statement is given in a timely manner if it is sent before the deadline by registered mail.

(4) The statement that must be given to another applies only when received.

(18) ARTICLE – ADDRESS CHANGES AND DELIVERIES

(1) The Insurance Company sends written notices to the Policyholder (including the Insured Party) at the address given upon conclusion of the Contract.

(2) The Policyholder or Insured Party must inform the Insurance Company of the change of their residence or registered office or their name or company name within 15 days from the day of the change.

(3) If an attempt is made to serve a letter via registered mail to the address given by the Policyholder at the time of conclusion of the Contract, or to the address communicated by the Policyholder to the Insurance Company during the term of the Contract, or to the address of the Policyholder's domicile, as indicated in the Central Population Register or at the business address of the company, as stated in the Business Register of Slovenia, was unsuccessful (e.g because the Policyholder did not pick up the mail or refused to accept it), the consignment is considered to have been served within the 15-day period within which the Policyholder could take the registered mail at the post office. As soon as the Policyholder becomes aware of the fiction of service of the shipment, he/she must inform the Insurance Company if he/she was unable to take over the mail for reasons not attributable to him/her. In this case, the mail shall be deemed to have been served upon receipt by the Insurance Company of a written objection of the Policyholder explaining all the circumstances of the case and providing evidence to justify the fact that he/she did not receive the registered mail within the given 15-day time limit, and that no one else under their written authority would have been able to receive the mail.

(4) The presupposition of a successful servicing attempt detailed in the previous paragraph shall produce legal effects on the basis of the contractual agreement concluded with the Insured Party.

(19) ARTICLE – CORRUPTION PREVENTION

A Contract where, in its own name or on behalf of another Contracting Party, a representative or intermediary of a public sector body or organisation, promises, offers or gives any illicit advantage to obtain a transaction or to conclude a transaction on more favourable terms, or to waive due control of the performance of contractual obligations or for any other conduct or omission, which causes damage to the public sector body or organisation or makes it possible to obtain an unauthorised benefit to a representative of an authority, an intermediary of a public sector body or organisation, another contracting party or its representative, agent, intermediary, is void.

(20) ARTICLE – SANCTIONS CLAUSE

(1) The Insurance Company does not provide insurance coverage and is under no obligation to repay the claim or pay any other benefit in the event that such repayment of the claim or payment of any other benefit would expose the Insurance Company to any sanctions, prohibitions, restrictions, export controls and/or the use of exchange rates based on United Nations resolutions or trade or economic sanctions, violations of the laws or regulations of the European Union, the United States of America, the United Kingdom, the Republic of Slovenia or the rules of any jurisdiction applicable to the Insurance Company.

(2) The Insurance Company does not provide insurance coverage and has no obligation to repay the claim or to pay any other benefits in connection with losses, damages or liabilities arising from activities in the sanctioned countries/territories or from activities directly or indirectly related to or for the benefit of their governments, to persons or entities resident in the sanctioned countries/territories, or to persons or entities in the sanctioned countries/territories or their territorial waters. This exclusion shall not apply to activities performed or services performed in an emergency situations for safety reasons or where the risk has been notified to the Insurance Company and the latter has confirmed the insurance coverage in writing.

(3) The sanctioned countries/territories referred to in the previous paragraph shall be considered to be the Crimea, Democratic People's Republic of Korea, Iran, Syria and Venezuela, the list of which may be amended. The current list of these countries is available at www.generali.si/sankcijska_klavzula.

(21) ARTICLE – INFORMATION ON THE PROCESSING OF PERSONAL DATA

(1) The Insurance Company respects the right to privacy of its clients. To this end, the Insurance Company has prepared a comprehensive "Information on the processing of personal data", which is available at www.generali.si/vop. The information may also be requested in writing via the toll-free telephone number **080 70 77** or the authorised representative of the Insurance Company.

(2) The Policyholder authorises the Insurance Company and the

Assistance Centre to obtain and inspect on its behalf the medical records and other documentation necessary to determine the circumstances of the conclusion of the insurance and to determine the obligations of the Insurance Company.

(22) ARTICLE – OUT-OF-COURT SETTLEMENT OF DISPUTES

If the Policyholder, Insured Party or other Beneficiary is dissatisfied with the service of the Insurance company, it may inform the Insurance Company. Consumers have the right to file an initiative to initiate mediation proceedings before the selected provider of out-of-court consumer dispute resolution, against the decision of the Insurance Company's commission's appeal committee before the Mediation Centre with the Slovenian Insurance Association, Železna cesta 14, SI-1000 Ljubljana, phone: +386 (0)1 300 93 81, e-mail: irps@zav-zdruzenje.si, website: www.zav-zdruzenje.si. More information on the appeal proceedings is available at www.generali.si/pritozbeni-postopki or via telephone **080 70 77**.

(23) ARTICLE – FINAL PROVISIONS

(1) Slovenian law applies to Contract relationships.
(2) The Agency for Insurance Supervision, Trg republike 3, Ljubljana, is competent for the supervision of the Insurance Company.
(3) The report on the solvency and financial position of the Insurance Company is available at www.generali.si.
(4) These Terms and Conditions apply from 3/1/2020 onwards.

INSURANCE COVERAGE TABLE FOR "TUJINA"

Insurance coverages OTHER COUNTRIES are applied based on the selected package ("TUJINA" or "TUJINA PLUS"), and the chosen combination.

INSURANCE COVERAGES		"TUJINA"			"TUJINA PLUS"		
		Combination A	Combination B	Combination C	Combination A	Combination B	Combination C
Total for all insurance coverage up to the sum insured (per person):		**EUR 25,000** EUR 20,000* EUR 1,000**	**EUR 50,000** EUR 40,000* EUR 2,000*	**EUR 100,000** EUR 60,000* EUR 3,000*	**EUR 25,000** EUR 1,000**	**EUR 50,000** EUR 2,000**	**EUR 100,000** EUR 3,000**
1.	Medical care and doctor's visit	√	√	√	√	√	√
2.	Treatment	√	√	√	√	√	√
3.	Medicines and medical devices	√	√	√	√	√	√
4.	Urgent dental treatment	EUR 100	EUR 200	EUR 300	EUR 100	EUR 200	EUR 300
5.	Transport to the nearest hospital or clinic and back	√	√	√	√	√	√
6.	Transportation home	√	√	√	√	√	√
7.	Transportation and accommodation for the person that accompanies the Insured Party	√	√	√	√	√	√
8.	Attendance and transportation of a minor	√	√	√	√	√	√
9.	Transportation of a family member	ticket	ticket	ticket	ticket	ticket	ticket
10.	Transportation of mortal remains to the Insured Party's Home country	√	√	√	√	√	√
11.	Return to Home country	√	√	√	√	√	√
12.	Flight cancellation				EUR 100	EUR 150	EUR 250
13.	Loss/theft of luggage				EUR 300	EUR 500	EUR 800
14.	Delay in luggage/flight				EUR 100	EUR 150	EUR 200
15.	Loss/theft of identity documents				EUR 100	EUR 150	EUR 200
16.	Bail advance payment				EUR 2,000	EUR 4,000	EUR 6,000
17.	Urgent money transfer				EUR 2,000	EUR 3,000	EUR 4,000
18.	Organisation of services upon changes when staying abroad				√	√	√
	Age limitation				75 years		
	Age limitation (additional premium required)				85 years		
	Age limitation (additional premium required)				over 85 years		
	Geographic validity				the entire world		
	√ – included						

* Applies to the insurance of persons with permanent residence abroad who are temporarily staying and working in the Republic of Slovenia.
** In the event of an acute deterioration of a chronic illness, all insurance coverages, regardless of the chosen sum insured, is jointly limited to that amount.

GENERALI zavarovalnica d.d., Kržičeva ulica 3, 1000 Ljubljana | Matična številka: 5186684000 | ID za DDV:88725324 I Okrožno sodišče v Ljubljani I
Osnovni kapital 39.520.347,18 EUR I Družba pripada zavarovalniški skupini Generali Group.