GENERAL TERMS AND CONDITIONS OF INDIVIDUAL HEALTH INSURANCE – PROMED

OI/3PRONH1

TABLE OF CONTENTS

LIST OF APPENDICES

GENERAL TERMS AND CONDITIONS OF INDIVIDUAL HEALTH INSURANCE – PROMED

OI/3PRONH1

Information referred to in Article 17(1) of the Act of 11 September 2015 on Insurance and Reinsurance Activity:

Type of information	Number of the editing unit of the template agreement
Conditions for payment of compensation and other benefits	§2(13); §3; §4; §5; §6; §7 GTCI*
Limitations and exclusions of liability of the insurance company entitling it to refuse to pay compensation and other benefits or to reduce them	§ 12 of the GTCI**

ADDITIONAL INFORMATION FOR THE INSURED PARTY AND THE POLICYHOLDER:

Please note that: relevant to the Policyholder and the Insured Party:

* conditions for payment of compensation and other benefits;

**limitations and exclusions of liability of the insurance company entitling it to refuse to pay compensation and other benefits or to reduce them

are also included in the wording of Appendices 1, 2, 3, 4 and 5 to the GTCI.

Therefore, the content of each Appendix contains a similar Information Table.

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Share capital: EURO 5,800,000.00

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CODE OI/3PRONH1

§1 Who are the parties to the Insurance Agreement?

1. The General Terms and Conditions of Individual Health Insurance – PROMED (hereinafter referred to as the GTCI) shall constitute the basis for concluding insurance agreements (hereinafter referred to as the Agreement) by and between:
   1) LMG Försäkrings AB with its registered office in Stockholm (102 51) (hereinafter referred to as we or the Insurer), Box 27093, Sweden which is registered with the Registrar of Companies under number 516406-0831, share capital: EUR 5,800,000, fully paid-up, operating in Poland through a branch named LMG Försäkrings AB SA Branch in Poland with its registered office in Warsaw (02-678), at ul. Szturmowa 2, entered in the Register of Entrepreneurs of the National Court Register kept by the District Court for the Capital City of Warsaw, 13th Commercial Division of the National Court Register, under KRS No 0000395438, Tax ID Number [NIP]: 1080011494, Statistical ID No [REGON]: 145156729, having the status of an entrepreneur within the meaning of the Act of 8 March 2013 on counteracting excessive delays in commercial transactions, the Insurer uses the trade name LUX MED Ubezpieczenia,
   2) and the Policyholders who are natural persons,
   3) for the benefit of the Insured Party.
2. The institution which has authorised the Insurer to conduct the insurance business is Finansinspektionen with its registered office in Stockholm (Sweden).

§2 Definitions

For better legibility of the document, in the GTCI we use the gender-neutral terms. The terms used in these GTCI and the documents which form an integral part of the Insurance Agreement shall have the following meanings:

1. Disease – a physical or mental condition of the body that is abnormal according to the generally accepted medical knowledge.
2. High-risk pregnancy – a pregnancy with risk factors from the mother or the foetus that increase the incidence of complications in pregnancy and childbirth which threaten the health or life of the mother or foetus. Within the meaning of GTCI, such pregnancy requires care or resolution at a level III perinatal care centre, according to the classification set out in the Regulation of the Minister of Health of 16 August 2018 on the organisational standard for perinatal care.
3. Hospitalisation – stay at a hospital ward, aimed at diagnosing or treatment, including operation. The stay shall take place within the prescribed period and may be postponed by at least 24 hours from the date it was deemed necessary, provided that the postponement may not exceed the period after which a serious deterioration of health or a significant reduction in chances of recovery, foreseeable by the doctor, may take place.
4. Hospital Care Coordinator – a representative of the Operator responsible for servicing the Insured Party in the performance of Hospital Services as part of the Hospital Care Coordination the scope of which is indicated in Appendices No 3, 4 and 5 to the GTCI, item Hospital Care Coordination.
5. Accident – a sudden event caused by a cause independent of the will or health condition of the Insured Party, in which the Insured Party suffered physical injury or a rupture of anatomical structures of the musculoskeletal system except for structures of the spine and chest. An Accident does not include Disease or disease conditions that occur suddenly.
6. Coverage Period – the period during which we provide insurance cover to the Insured Party.

7. Medical Operator (hereinafter referred to as the Operator) – an entity coordinating the provision of Outpatient or Hospital Services on our behalf.
8. Policy – a document confirming the conclusion of the Agreement and its terms and conditions.
9. Medical Facility – a healthcare institution indicated by us that provides Outpatient Services within the meaning of the Act of 15 April 2011 on medical activity, operating in the territory of and in accordance with the law in force in the Republic of Poland – from among the entities provided in the list currently updated by us at: https://www.luxmed.pl/placowki.
10. Policy Anniversary (hereinafter: Anniversary) – the day of the year corresponding to the date of conclusion of the Agreement, and if in a given calendar month there is no day of the month corresponding to that date – the last day of that month.
11. Premium – the amount due to us under the Agreement.
12. Hospital – a healthcare institution indicated by us that provides Hospital Services within the meaning of the Act of 15 April 2011 on medical activity, operating in the territory of and in accordance with the law in force in the Republic of Poland, providing Hospital Services to the Insured Party. The definition of a Hospital within the meaning of the GTCI also includes Medical Facilities which are part of the Hospital. The list of Hospitals (hereinafter referred to as the List of Hospitals) is updated on an ongoing basis and is available at: https://www.luxmed.pl/dla-pacjenta/ubezpieczenia-dla-klientow-indywidualnych/ubezpieczenie-szpitalne-lux-med-pelna-opieka and in the search engine at: https://www.luxmed.pl/placowki.
13. Service – a service that we will provide or an amount we will pay to the Insured Party in the event of an event covered by the scope of the coverage. The services specified in the Agreement are the following:
    1) Outpatient Service – a healthcare service provided to the Insured Party by the Medical Facility on an outpatient basis. The scope of Outpatient Services is indicated in Appendices 1, 2, 3, 4 and 5 to the GTCI, item Outpatient Services.
    2) Second Medical Opinion Service – a service provided to the Insured, being an opinion on: the diagnosis, health condition and treatment of the Insured Party, prepared by a team of WorldCare specialists on the basis of the provided medical documentation. The service is provided for the following illnesses or conditions: cancer, myocardial infarction, coronary artery disease requiring surgery, coma, cerebral stroke, multiple sclerosis, paralysis, plegia, paresis, chronic obstructive pulmonary disease, emphysema, inflammatory bowel disease, chronic liver disease, kidney failure, chronic pelvic pain, diabetes, venous thromboembolic disease, amputations, rheumatoid arthritis, severe burns, sudden loss of vision due to disease, large organ transplant, neurodegenerative disease/Alzheimer's disease, hearing loss, hip and knee replacement surgery, loss of speech, serious injuries, Parkinson's disease.
    3) Cash Benefit – the amount we will pay to the Insured Party in the event of the incident referred to in § 3(3)(3); the annual limit of the Cash Benefit, which is specified in amounts in Appendices No 2, 3, 4 and 5 to the GTCI, item Dental Duty, constitutes the upper limit of our liability towards the Insured Party during each 12-month Coverage Period.
    4) Hospital Service – a service related to Hospitalisation within the scope of orthopaedics, provided in the Hospital, including the Hospital Care Coordination. The scope of Hospital Services is indicated in Appendices No 3, 4 and 5 to the GTCI, item Orthopaedic Care.
14. Insured Party – the Main Insured Party or the Co-Insured Party who became covered by the insurance coverage pursuant to the GTCI:
    1) Main Insured Party – a natural person on whose account the Agreement was concluded, who on the date of commencement of the Coverage Period was at least 18 years of age and not yet 70 years of age.
    2) Co-Insured Party – the natural person named by the Policyholder in the Insurance Application whose

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health is covered under the Agreement and who is not the Main Insured Party for whose account the Agreement is concluded. A Co-Insured Party may be:

a) Partner – a spouse or a person running a joint household with the Main Insured Party, not related by kinship, adoption or affinity, who on the date of commencement of the Coverage Period was at least 18 years of age and not yet 70 years of age;

b) Child – own child or adopted child of the Main Insured Party or of the Partner, who on the date of commencement of the Coverage Period was not yet 26 years of age. The person authorized to make declarations on behalf of the minor child (not yet 18 years of age) shall be their legal guardian.

15. Insurance Application – a proposal to conclude an Insurance Agreement submitted to us by the Policyholder.

16. WorldCare – WorldCare International, Inc., a Delaware corporation, USA, with registered number 2523480, having its registered office at 7 Bulfinch Place, Suite 301, Boston, MA 02114, the provider of the Second Medical Opinion Service.

§3 What is the subject matter of the Agreement and what is within its scope?

1. The subject matter of the insurance is the Insured Party's health.
2. The scope of insurance covers the provision of Services referred to in §2(13) to the Insured Party. The detailed scope of Services to which the Insured Party is entitled depends on the selected insurance Option and is indicated in section 4.
3. We provide the Insured Party with insurance coverage:
   1) with respect to Outpatient Services in the event of justified medical reasons;
   2) with respect to Hospital Services in respect of the consequences of an Accident, for which the Hospitalisation, in accordance with medical indications, should be provided within a period not exceeding 30 days from the date of the Accident. The event giving rise to our obligation to provide a Hospital Service is the joint occurrence of the following during the Coverage Period: An Accident as defined above and the related referral for hospital treatment (the date of the event is the date of the referral);
   3) with respect to Cash Benefits – the event giving rise to the obligation to provide a Cash Benefit is the fact that the Insured Party, during the Coverage Period, benefits from a paid Outpatient Service (dental duty), the scope and conditions of which are specified in Appendices No 2, 3, 4 and 5 to the GTCI, item Dental Duty;
   4) with respect to the Second Medical Opinion Service – the event giving rise to the obligation to provide the service by us shall be the diagnosis, determination of bodily injury or determination of the necessity to conduct surgical treatment or a procedure in respect of the illnesses or conditions indicated in §2(13)(2) of the GTCI by the physician treating the Insured Party in the territory of the Republic of Poland.
4. The Agreement may be concluded in one of the following insurance Options (hereinafter referred to as the Option):
   1) BASIC Option – for which Outpatient Services covered by the insurance are indicated in Appendix No 1 to the GTCI;
   2) STANDARD Option – for which Outpatient Services and Cash Benefits covered by insurance coverage are specified in Appendix No 2 to the GTCI;
   3) EXTENDED Option – for which Outpatient Services, Cash Benefits, Hospital Services and Hospital Care Coordination, and the Second Medical Opinion Service covered by insurance coverage are specified in Appendix No 3 to the GTCI;
   4) COMPREHENSIVE Option – for which Outpatient Services, Cash Benefits, Hospital Services and Hospital

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Care Coordination, and the Second Medical Opinion Service covered by insurance coverage are specified in Appendix No 4 to the GTCI;

5) PREMIUM Option – for which Outpatient Services, Cash Benefits, Hospital Services and Hospital Care Coordination, and the Second Medical Opinion Service covered by insurance coverage are specified in Appendix No 5 to the GTCI.

5. The agreement may be concluded in one of the following Types of insurance (hereinafter referred to as the Type), which specify who will be covered by insurance coverage:
   1) Individual Type, where the Policyholder:
      a) is at the same time the Principal Insured Party and concludes the Agreement for its own benefit, or
      b) enters into an Agreement for the benefit of a third party who becomes the Principal Insured Party;
   2) Partner Type, where the Policyholder:
      a) is at the same time the Principal Insured Party and concludes the Agreement for its own benefit and for the benefit of one Co-insured Party (one Partner or one Child), or
      b) enters into an Agreement for the benefit of a third party who becomes the Principal Insured Party, and for the benefit of one Co-insured Party (one Partner or one Child);
   3) Family Type, where the Policyholder:
      a) is at the same time the Principal Insured Party and concludes the Agreement for its own benefit and for the benefit at least two Co-insured Parties (one Partner and one or more Children), or
      b) enters into an Agreement for the benefit of a third party who becomes the Principal Insured Party, and for the benefit at least two Co-insured Parties (one Partner and one or more Children).
6. In the Partner Type or the Family Type, the Insurance Option is the same for all Insured Parties covered by insurance coverage.

§4 What are the general rules for using the insurance?

1. In order to take out insurance, you should notify us of the event covered by the Agreement. The manner of reporting an event varies between the Services – the details are described in §5–7 of the GTCI.
2. Upon receipt of the Service application (except for the Outpatient Service), within no more than 7 days from the date of receipt thereof, we inform the Insured Party or the claimant about this fact and take steps to determine the validity of the claim and specify the amount of the Service.
3. If additional documents or information are needed to determine whether the person applying for the Service (except for the Outpatient Service) is entitled to the Service, within no more than 7 days from the date of receipt of the Service application, we will inform the Insured Party or claimant thereof. We will provide the information in writing or in any other manner as agreed upon by that person.
4. We will commence the provision of the Service no later than 30 days from the receipt of the application for the provision of the Service. The Insured Party may indicate another later date.
5. It may be impossible to determine whether the Insured Party or the entitled person is entitled to the Service within the time limit specified in section 4. In such a situation, we shall commence the provision of the Service within 14 days from the date on which it was possible to clarify all the circumstances, while exercising due diligence.
6. When verifying the Service application, we can determine that the Insured Party is not entitled to the Service. We will inform the person filing the application thereof in writing and indicate the legal basis and the circumstances that justify the refusal.

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§5 How to benefit from Outpatient Services and Cash Benefits?

1. Outpatient Services are provided only in the Medical Facilities indicated by us, in accordance with their working hours and scope of work.
2. The Insured Party may use the Outpatient Services within the scope and on the terms and conditions of their provision specified in Appendix No 1, 2, 3, 4 or 5 (depending on the selected Option) to the GTCI, item Outpatient Services.
3. In the event of doubts about the medical validity or medical insecurity of a medical procedure resulting from a referral presented by the Insured, we shall have the right to verify the validity of the medical referral presented by the Insured.
4. In the event of verification of a referral presented by the Insured, we may request to see the medical information related to the referral issued.
5. In the case of:
   1) the medical referral is unfounded,
   2) the medical procedure resulting from the referral is not medically safe, or
   3) you fail to provide us with access to medical information and as a result we are unable to verify the referral,

   we will refuse to provide the Insurance Benefit resulting from your referral.
6. In order to benefit from Outpatient Services, the Insured Party shall notify the Operator of his/her intention to benefit from the Service in a manner of his/her choice:
   1) electronically via the Internet platform made available by the Operator,
   2) by phone via the Operator's Hotline (telephone available at www.luxmed.pl),
   3) personally in a Medical Facility, the current list of which can be found on the website at: https://www.luxmed.pl/placowki,

   and shall agree on the place and date of the provision of the Outpatient Service.
7. The Insured Party is obliged to cancel the visit no less than 4 hours before the scheduled visit if he/she cannot appear on time.
8. If the Outpatient Service is to be provided to a person under the age of 18, the Medical Facility may require the statutory representative to present the documents specified in the standards of service for minor patients used by that Medical Facility prior to the provision of the service.
9. In order to receive the Cash Benefit, the Insured Person should:
   1) fill in a request for payment of a Cash Benefit, which is available on the website at: https://www.luxmed.pl/dla-pacjenta/ubezpieczenia-dla-klientow-indywidualnych/indywidualne-ubezpieczenie-zdrowotne-promed in item Detailed scopes/documents to be downloaded;
   2) attach a copy of the personal bill (invoice) for the services provided as part of the dental duty;
   3) deliver the documents to us by sending them to the following e-mail address: roszczenia.ubezpieczenia@luxmed.pl, or by traditional post to the address indicated in the application for payment of the Cash Benefit.
10. A personal bill (invoice) issued by the Medical Facility which provided the Outpatient Service (dental duty) should contain:
    1) details of the Insured, i.e. at least: first and last name, address; in the case of a Child under the age of 18, a personal account (invoice) should be issued to the statutory representative, and it should contain the Child's details,

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2) a list of healthcare services provided to the Insured Party together with the name of the service or a copy of the documentation of the completed healthcare service,
3) the number of healthcare services of a given type,
4) the date of provision of the healthcare service,
5) the unit price of each healthcare service provided.

§6 How to benefit from Hospital Services?

1. Hospital Services are provided only in Hospitals indicated by us, within the scope and on the terms and conditions of their provision specified in Appendices No 3, 4 or 5 (depending on the selected Option) to the GTCI, item Orthopaedic Care.
2. In order to benefit from the Hospital Services, the Insured Party shall:
   1) contact the Hospital Care Coordinator who will support him/her in the scope specified in Appendices No 3, 4 or 5 (depending on the selected Option) to the GTCI, item Hospital Care Coordination. Contact details for the Hospital Care Coordinator are provided by us to the Policyholder immediately after the conclusion of the Agreement;
   2) inform the Hospital Care Coordinator about receiving a referral for hospital treatment of the consequences of an Accident.
3. In order to decide on the provision of the Hospital Service, we need the following documents:
   1) a complete and correctly completed application for the provision of the Hospital Service;
   2) a copy of the referral to the Hospital and a copy of medical documentation held by the Insured Party;
   3) a copy of the documentation confirming the circumstances of the Accident:
      a) issued in proceedings conducted by the police or public prosecutor's office in court proceedings, if such proceedings were conducted,
      b) or a court judgement concerning the circumstances of the Accident, if issued,
      c) or a written description of the circumstances of the Accident drawn up by the Insured Party.
4. If the Hospital Service is to be provided to a person under the age of 18, the Hospital may require the statutory representative to present the documents specified in the standards of service for minor patients used by that Hospital prior to the provision of the service.

§7 How to benefit from Second Medical Opinion Service?

1. The Second Medical Opinion Service shall be provided to the Insured Party not earlier than 90 days after the first day of the Coverage Period.
2. In order to benefit from the Second Medical Opinion Service, the Insured Party should contact WorldCare in Poland at +48 (22) 221 06 41 and provide: the medical documentation possessed by the Insured Party confirming the diagnosis of the illness covered by this Service and the proposed treatment plan.
3. Information concerning the Second Medical Opinion Service can be found in Appendices No 3, 4 or 5 (depending on the selected Option) to the GTCI, item Second Medical Opinion Service.

§8 What do we require for the conclusion of the Agreement?

1. If you conclude the Contract remotely, the information on the insurance premium for the insurance cover is binding:
   1) until the end of its presentation in the sales application or
   2) until the end of your telephone conversation on the conclusion of the Agreement.
2. You may enter into a Contract with us after you and the Insureds have provided all the information and

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circumstances known to you which are required in the Application for Insurance and other information necessary to enter into the Contract which we will ask before we enter into the Contract. We will accept Applications that are complete and correctly filled in.

3. We shall not be liable for the consequences of circumstances that arise because we were not informed of relevant matters relating to the Insured's health that we asked about.
4. You submit your Insurance Application via the electronic application.
5. If the Insurance Application does not contain all the required information or documents, then we will notify you immediately and ask you to complete it, indicating a 14-day deadline for completing the deficiencies.
6. If you do not provide us with the information or documents by the deadline indicated by us, we will regard this as a withdrawal from your application to conclude the Contract. We will cancel the Application you have submitted and as a consequence no Contract will be concluded on the basis of it, but you may submit a new Insurance Application.
7. The contract is concluded subject to the following conditions being met together:
   1) acceptance by us of the Insurance Application and
   2) payment of the Premium or the first instalment of the Premium by the Policyholder.

   The moment the agreement is concluded is when both of the above conditions are met.
8. The conclusion of the Insurance Agreement shall be confirmed by the Policy.
9. When using the option of concluding the Agreement at a distance, the Policyholder shall not bear any other costs resulting from the use of the means of remote communication other than the costs of:
   1) an Internet connection allowing for the use of the electronic application and e-mail address indicated by the Policyholder during the conclusion of the Agreement, to which the Policy and other documents relating to the Agreement will be sent after its conclusion,
   2) a telephone call to contact us if it is the customer who contacts us by telephone to conclude the Contract.

§9 For how long the Agreement is concluded and what are the conditions for extending the insurance cover?

1. The Contract is concluded for a period of 12 months, starting on the first day of the Period of Protection. You will find the start date of the Period of Protection on the Policy.
2. The Insured shall be covered from the day on which the Period of Cover begins.
3. The Agreement may be renewed (cover may be extended) on the Anniversary for another 12-month Period of Cover under the terms and conditions set out in section 4- 8 below.
4. At renewal and extension of cover, we shall have the right to propose a change in the Premium due to an increase in the costs we incur for the benefits provided under the Contract.
5. We will send you a proposal to change your Premium at least 30 days before the Anniversary.
6. If the Policyholder accepts our proposal referred to in section 5 above, he shall pay the Premium or its first instalment in the new amount not later than on the due date indicated in our proposal. The payment of the Premium or the first instalment thereof in the new amount shall constitute confirmation of the Insurer's willingness to extend the cover for a further 12-month Period of Cover from the first day following the last day of the preceding Period of Cover.
7. If the Policyholder does not pay the Premium or the first instalment thereof in the new amount by the due date indicated in our proposal, we shall consider him or her as not agreeing to change the amount of the Premium and extend the cover for the next 12-month Period of Cover. In this case, the Agreement will expire at the end of the period for which it was concluded.
8. Protection will not be extended, and the Contract will not be renewed for a further 12-month Period of

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Protection, if, at least 10 days before the Anniversary, at least one of the parties makes a statement to the other party expressing disagreement with the extension.

9. The Agreement shall be terminated:
   1) on the date of death of the Insured Party,
   2) on the date on which we received the notice of withdrawal from the Agreement, submitted within 30-day withdrawal period;
   3) upon the lapse of the last day of the notice period;
   4) at the end of the last day of the term of the Agreement, if the coverage is not extended on an Anniversary.

§10 When is it possible to withdraw from or terminate the Agreement?

1. The Policyholder shall have the right to withdraw from the Agreement without stating any reason within a period of 30 days from the date of being informed about the conclusion of the Agreement or from the date of confirmation of information referred to in the Act on Consumer Rights, if this is later. The deadline shall be deemed to have been met if the declaration is sent before its expiry. Withdrawal from the Agreement shall not release the Policyholder from the obligation to pay the Premium for the period during which we provided cover
2. Where the Policyholder concludes the Agreement by means of distance communication, the Policyholder agrees to the commencement of the provision of cover before the expiry of the deadline for withdrawal from the Agreement in accordance with section 1.
3. Withdrawal from the Contract shall be made by the Policyholder by submitting to us a declaration of withdrawal from the Contract. The withdrawal can be sent to our e-mail address: obslugaubezpieczenia_ind@luxmed.pl. Sending the declaration before the expiry of the withdrawal period shall be sufficient to meet the deadline.
4. The Policyholder has the right to terminate the Agreement at any time with one month's notice, which starts on the 1st day of the month immediately following the date of submitting the termination notice by the Policyholder. You can send the termination notice to our e-mail address: obslugaubezpieczenia_ind@luxmed.pl.
5. We may terminate the Agreement with one month's notice only in the cases specified in the Act and for important reasons specified below:
   1) the Insured Party or the Policyholder committing a prohibited act within the meaning of Article 115 §1 of the Act of 6 June 1997 Penal Code, in connection with the conclusion or performance of the Agreement;
   2) persistent violation by the Insured Party or the Policyholder of personal rights or other rights of the Insurer or entities or persons through whom the Insurer performs the Agreement, after having called upon the Insured Party or the Policyholder in writing to cease the above-mentioned violations;
   3) repeated failure by the Insured Party or the Policyholder to comply with the rules of organisation of work in Medical Facilities and Hospitals or failure to comply with the instructions of such personnel, after having called on the Insured Party or the Policyholder to refrain from the above-mentioned actions;
   4) repeated breach by the Insured Party or the Policyholder of the organisational rules of the Medical Facilities and Hospitals, after having called on the Insured Party or the Policyholder to refrain from the above-mentioned actions.
6. Termination of the Agreement in the manner referred to in sections 4 -5 above shall not release the Policyholder from the obligation to pay the Premium for the period in which we provided insurance coverage, including one month's notice.

§11 What is the amount of the Premium and how to pay it?

1. The premium for the insurance may be paid by the Policyholder monthly, quarterly, semi-annually or annually.
2. Details of the amount of the Premium and the method of payment are indicated in the Policy.
3. The date of payment of the Premium or any instalment thereof shall be the date on which the Policyholder's payment in full due amount is credited to the bank account indicated in the Policy.
4. If the Policyholder has not paid the Premium or its first installment within the prescribed period, we may terminate the Agreement with immediate effect and demand payment of the Premium for the period for which we have provided coverage. If we do not terminate the Agreement in accordance with the preceding sentence, the Agreement shall expire at the end of the period for which the Premium or its first installment was not paid.
5. If the next Premium installment is not paid, when the Premium is paid in installments, we will call on the Policyholder in writing to pay it within an additional period of 7 days from the date of receipt of the call, informing the Policyholder of the consequences of non-payment. If the Premium installment is not paid by the Policyholder within this additional deadline, the Agreement shall expire on the last day of the additional time limit set by us in the request for payment of the Premium.
6. In the event of termination or expiration of the Agreement before the expiry of the period for which it was concluded and for which the Premium was paid, the Policyholder shall be entitled to a refund of the Premium for the unused Coverage Period.
7. Early termination or expiration of the Agreement shall not release the Policyholder from the obligation to pay the Premium for the period (including the notice period of the Agreement) in which we provided the insurance coverage.

§12 What are the exclusions from insurance that will cause us not to provide the Service?

1. The scope of insurance does not cover Hospital Services provided to the Insured Party for the purpose of saving life in accordance with the Act of 8 September 2006 on State Medical Rescue.
2. Our liability does not extend to events (that is we will not provide a Service in cases) that result from:
   1) acts of war, hostilities, martial law, civil war, riots, state of emergency, civil coup d'état, acts of terrorism, military service, participation in military or stabilisation missions, the Insured Party's active participation in riots, commotions or strikes;
   2) the use of scientifically unrecognised methods of treatment and/or unconventional, folk and oriental medicine, the use of medicines not authorised for use in Poland and their consequences, as well as the Insured Party's participation in medical experiments, clinical trials or similar health-related research and their consequences;
   3) transplantation of organs or tissues, cells, cell cultures (of natural or artificial origin), including by means of autologous transplantation, implantation of implants and devices;
   4) practising competitive sports by the Insured Party – that is: practicing sports disciplines requiring physical activity covering: participation in training within a sports club, union or association, as well as practising sports disciplines for profit; participation in sports competitions (competitions, matches, tournaments, other sports events), and sports fitness or training camps. It also covers trips to places with extreme climatic or natural conditions. The following are not competitive sports:
      a) recreational sports in free time aimed solely at leisure, rehabilitating psychophysical forces or maintaining good health,
      b) practising sports disciplines by children under 18 years of age in a sports club, class or school.
   5) practising high-risk sports by the Insured Party – i.e. sports whose practising poses a particular risk to the

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t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
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Insured Party's health. Within the meaning of the GTCI these include: aerial sports and the piloting of any motor aircraft, ballooning, parachute jumping, line jumping, mountain cycling, motor and motor-water sports, water jet skiing, alpinism, mountain climbing, rock climbing, speleology, cave mountaineering, ski jumping, snowboard and skiing except for recreational activities on designated routes, bobsleighs, rafting and other water sports practiced on mountain rivers, diving with specialist equipment, fighting, hunting and horse riding;

6) states of emergency due to natural disasters, acts of God, states of pandemic and states of epidemic declared and confirmed by the competent government authorities, if they cause disruption or inability to provide services on our part;
7) the effects of nuclear energy, radioactivity and electromagnetic fields, as well as biological and chemical agents, to the extent that they are harmful to humans;
8) driving a vehicle without a licence, driving a vehicle without a valid MOT certificate as required under the applicable regulations, or driving a vehicle under the influence of alcohol, drugs or other intoxicants, psychotropic drugs or substitutes within the meaning of the Act of 29 July 2005 on counteracting drug addiction;
9) attempting to commit suicide, attempting or deliberately inflicting self-harm, consciously causing health disorder by the Insured Party,
10) committing or attempting to commit a crime or offence;
11) wilful misconduct, self-diagnosis, treatment, modification of prescribed treatment or gross negligence by the Insured Party;
12) being under the influence, abusing or being poisoned as a result of the voluntary consumption of: alcohol, drugs, other intoxicants or psychotropic substances, medicines used contrary to a doctor’s prescription, and tobacco abuse or poisoning;
13) detoxification, rehabilitation and drug treatment;
14) treatment of mental illnesses, disorders or other mental disturbances, including Alzheimer’s disease, and their consequences;
15) obtaining Services by means of prohibited acts, attempts at extortion or actions meant to deliberately mislead the Insurer.

3. Taking into account medical safety standards, the Medical Facility or Hospital may provide the Service to a particular patient with priority over other patients.
4. A Medical Facility or Hospital shall have the right to refuse the Service to the Insured Party if it violates the principles of social coexistence or the organisational rules of the Hospital or Medical Facility, as well as if it hinders the work or functioning of the facility or its personnel.
5. In addition, our responsibility for Outpatient Services does not include:
   1) diagnosis and treatment of fertility disorders, including pregnancy resulting from the above-mentioned procedure, provided that it is a high-risk pregnancy;
   2) diagnosis and treatment related to gender reassignment;
   3) conduct of abortion procedures and treating their consequences;
   4) managing a high-risk pregnancy;
   5) prosthetic, orthodontic, periodontological, implantological diagnosis and treatment;
   6) diagnosis, treatment and surgeries or operations in the field of aesthetic medicine, plastic surgery and cosmetology, as well as treatment of their consequences;

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7) issuing judgments, certificates, statements, applications not related to the necessity to continue the diagnostic and therapeutic process conducted in Medical Facilities or Hospitals designated by us;

8) sanatorium and health resort treatment and rehabilitation stays in a nursing home or other health care or treatment and nursing facility in which the Insured Party is present due to medical, family or social reasons;

9) treatment of HIV (AIDS), viral hepatitis (excluding hepatitis A) infections and diseases resulting from the above-mentioned infections;

10) which are outside the scope of health services indicated in the Insurance Option used by a given Insured Party.

6. In addition, our responsibility regarding the Hospital Service does not include:

1) immediate treatment of sudden conditions identified on the date of admission to the hospital ward (e.g. cerebral stroke, myocardial infarction, pancreatic inflammation, pulmonary congestions); treatment under conditions of intensive care unit (in particular: Department of Anaesthesiology and Intensive Care, Department of Intensive Cardiology Supervision, Department of Stroke Treatment, Department of Intensive Neurological Care, Department of Asthma Treatment) or with the provision of intensive kidney substitute therapy, liver dialysis, ECMO, mechanical ventilation, contrapulsation;

2) The Hospitalisation which, for medical safety reasons identified on the date of admission to a hospital ward or during a stay, requires one-time high-level and multi-specialist treatment in a medical facility not included in the List of hospitals, or its scope exceeds the scope referred to in §1, item Orthopaedic Care, Appendices No 3, 4 and 5 to the GTCI;

3) tests or consultations on medical treatment before Hospitalisation referred to in §2, item Orthopaedic Care, Appendices No 3, 4 and 5 to the GTCI, ordered by a medical facility other than the one indicated by us;

4) medical treatment after Hospitalisation within the scope described in § 3, item Orthopaedic Care, Appendices No 3, 4 and 4 to the GTCI, related to Hospitalisation performed in facilities other than those indicated by us;

5) rehabilitation other than listed in §4, item Orthopaedic Care, Appendices No 3, 4 and 4 to the GTCI;

6) treatment of multi-organ injuries (i.e. injuries involving several systems or organs at the same time and causing significant damage to at least two areas of the body, potentially disturbing the cardiovascular and respiratory stability of the injured person. Each of these injuries may constitute a condition directly threatening life. In particular, such injury includes conditions requiring urgent torakosurgery, neurosurgery and staying in anaesthesiology and intensive treatment) and their consequences;

7) diagnosis and treatment of congenital genetic defects related to chromosomal aberrations and congenital defects causing the diagnosed disability and their consequences;

8) diagnosis, treatment and surgeries or operations in the field of aesthetic medicine, plastic surgery resulting from non-medical indications and cosmetology, as well as treatment of their undesirable consequences;

9) diagnosis and treatment not provided in Hospitals or Medical Facilities designated by us and their consequences;

10) issuing judgments, certificates, statements and applications not related to the necessity to continue the diagnostic and therapeutic process conducted at the Hospital or Medical Facility designated by us (exclusion does not apply to certificates of incapacity for work or study);

11) sanatorium and health resort treatment and rehabilitation stays in a nursing home or other health care or treatment and nursing facility in which the Insured Party is present;

12) treatment of the consequences of infection with HIV, SARS-CoV-2, viral hepatitis (excluding hepatitis A);

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13) domestic treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;

14) diagnosis and treatment without medical indications;

15) treatment resulting from psychological indications;

16) detoxification, rehabilitation, drug treatment, and their consequences;

17) treatment of mental, dementitious, neurodegenerative diseases (including Alzheimer's disease) and their consequences.

7. We will not provide a Hospital Service to you if it results from Accidents and injuries that occurred or were treated in the period preceding the commencement of the Coverage Period.

8. We will not provide Hospital Services or Outpatient Services in Hospitals and in Medical Facilities other than those indicated by us.

9. We are not liable for any events resulting from:

1) medical errors,

2) errors in improperly maintained medical records of the Insured Party.

The healthcare entity providing the Service shall be responsible for the errors listed in section 9(1) and (2).

10. We do not provide a Second Medical Opinion Service if:

1) the application for the Service is submitted within 90 days of the first day of the Coverage Period;

2) the application for the Service concerns diseases or conditions other than those listed in §2(13)(2) of the GTCI;

3) The Insured Party has not performed full diagnosis of the disease or condition, referred to in §2(13)(2) of the GTCI in the territory of the Republic of Poland, and the physician treating them in the Republic of Poland did not present a diagnosis and did not propose a treatment plan.

11. In each 12-month Coverage Period, Cash Benefits for the Insured shall be paid up to the maximum of the annual limit specified in the amount specified in Appendices No 2, 3, 4 or 5 (depending on the selected Option) to the GTCI, item Dental Duty.

§13 What are the obligations of the Policyholder and the Insured Party towards us?

1. The Policyholder is obliged to:

1) pay the full amount of the Premium due to the bank account indicated in the Policy in the amount and within the time limits specified in the Policy;

2) immediately notify us, not later than within 14 days, of any change in your correspondence address;

3) inform us about any change in the Insured Party's and the Policyholder's particulars influencing the Agreement;

4) provide the Insured with the terms and conditions of the Agreement, including in particular the GTCI, before the Insured Parties give their consent to the provision of insurance coverage, if such consent is required, or if the Insured agrees to finance, even partially, the cost of the Insurance Premium, before the Insured Party gives their consent thereto. This obligation shall also apply to the service of documents making any amendments to the Agreement during its term;

5) inform about the death of the Insured Party;

6) inform the Insured Parties about any change of the hotline number under which the Insured Party may obtain information about the insurance and about any changes concerning the Operator.

2. The Insured Party is obliged to:

1) notify us within 30 days of the occurrence of an Accident about the occurrence of an Accident and about the issue of a referral for hospital treatment of its consequences. In the event of a breach of the obligations specified in the preceding sentence due to willful misconduct or gross negligence, we may reduce the service accordingly if the breach contributed to increasing the damage or prevented us from determining the circumstances and the consequences of the accident;
2) comply with physicians' recommendations;
3) comply with the rules applicable in Medical Facilities and Hospitals;
4) follow the instructions of the staff in the Medical Facilities and Hospitals;
5) comply with the Service performance deadlines agreed with us;
6) arrive at a Hospital indicated by us or inform the Medical Operator about the resignation from the Hospital Service within the agreed time limit, no later than 12 hours before the agreed date of its provision. If the circumstances do not allow to keep this time limit, the Insured Party shall inform the Medical Operator about the resignation immediately after the reason for it arose;
7) refrain from any activities hindering or preventing the provision of Services, or increase the damage or prevent us from determining the circumstances and effects of the insured accident;
8) produce an identity document with a photograph prior to the Service provision. Where the beneficiary of the Service is a Minor Child, an adult accompanying person may also be asked to produce an identity document;
9) undergo examination by physicians appointed by us to determine whether the claim is well founded;
10) provide us, together with the application for the Service, with all the medical documentation in our possession which is related to the reported event and to cooperate with us if the documentation provided requires supplementation or if additional information is necessary to establish our liability for the reported claims.

§14 What obligations do we have towards the Policyholder and Insured Parties?

1. Prior to the conclusion of the Agreement, we are obliged to provide the Policyholder with the GTCI together with Appendices. We provide the GTCI and its Appendices to the Policyholder in electronic form, so that the Policyholder can store and reproduce them in the ordinary course of business.
2. In order to confirm the conclusion of the Agreement and its terms and conditions, we will issue and deliver the Policy to the Policyholder.
3. We will inform the Policyholder, no later than within 14 days, about a change of our mailing addresses and a change of the hotline number under which the Insured Party can obtain information about the insurance.
4. We will perform our obligations under the Agreement correctly and in a timely manner, including the provision of Services.

§15 Processing of personal data of the Insured Parties.

1. We are the controller of personal data of the Policyholder and the Insured Parties within the meaning of Article 4(7) of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 (hereinafter: “Regulation”). The data shall be processed for the purposes of concluding the Agreement and providing insurance coverage. If the Policyholder or the Insured Party has consented to the processing of personal data for marketing purposes or to receive marketing communication, the personal data controllers are entities from the LUX MED Group – their list can be found at www.luxmed.pl. In any matters related to the processing of personal data by us, you can contact our Data Protection Officer available at the e-mail address: daneosobowe@luxmed.pl.
2. The Policyholder provides us with his/her personal data when concluding the Agreement. The Insured Parties'

personal data is provided to us by submitting an Insurance Application (in the case of Co-Insured Parties, their personal data is provided to us by the Policyholder, who may but does not have to be the Primary Insured). We process personal data of the Insured Parties listed in the Application, i.e. first and last name, Personal ID No (PESEL), sex, date of birth, main place of care, address of residence. If the Insured Party is a foreigner, we also process information about nationality and ID document number. In connection with providing the Policyholder with the opportunity to submit an Application via the electronic platform and to obtain insurance coverage through it for the Insured Parties submitted by the Policyholder, we will also process the e-mail address and telephone number of the Policyholder as well as the e-mail addresses and telephone numbers of the Insured Persons. We may ask the Insured Party to provide additional information about his/her health condition or, on the basis of an authorisation granted by the Insured Party, ask the medical entities used by him/her to obtain the information necessary to make a decision on the provision of the Service, its correct coordination or winding-up proceedings in connection with the claim. If, for the purposes referred to in the preceding sentence, it is necessary to obtain the Insured Party's medical records, we will ask you to provide us with a copy of it to the extent necessary, or on the basis of your consent, we will request the relevant medical authorities to make the said records available.

3. Consent to the processing of data for marketing purposes includes all information provided to us by the Policyholder or the Insured Party. These may include, for example, identification data (name and surname, gender, date of birth, age, place). However, we assure you that we will never use the medical records that you have provided to us or that we obtain from a healthcare professional under your appropriate authorisation – this information may only be accessed by authorised persons.
4. We process personal data of the Policyholder and the Insured Parties as the Insurer, and the purpose of this processing is the performance of the Agreement. First of all, we need to accept the Application. This will allow us to establish the identity of the Insured Party before the Service is provided and allow us to execute the Agreement and to contact the Insured Party. As the Insurer, we are obliged by law to process personal data in the course of its performance, including for the purpose of coordinating the Insured Party's use of Services (Article 6(1)(b) of the Regulation in conjunction with Article 41(1) of the Act of 11 September 2015 on insurance and reinsurance activity). The legal basis for such action on the part of the Insurer lies in the regulations governing our business activity as an insurance entity. However, we inform you that the Insured Party always has the right not to be subject to a decision based on automated processing of personal data, and to request human intervention, which we ensure. As a data controller who is an entrepreneur, we have the right to process personal data in order to pursue claims related to our business activity (Article 6(1)(b) and (f) of the Regulation, as the so-called legitimate interest of the controller, which is the pursuit of our claims and protection of our rights). If the Policyholder or the Insured Party share with us their opinion about the Services or submit a complaint, we may process personal data to consider the application and respond to it (Article 6(1)(f) of the Regulation, as the so-called legitimate interest of the controller, which is the processing of claims and the protection of the Insurer’s interests). As an entrepreneur, we keep accounting books and have tax obligations – we issue e.g. bills for the services we render, which may involve the need to process personal data (Article 6(1)(c) of the Regulation in conjunction with Article 74(2) of the Act of 29 September 1994 on accounting). If the Policyholder or the Insured Party has consented to the processing of personal data for marketing purposes, we may process personal data in order to send marketing communications to the Policyholder or the Insured Party concerning the activities of LUX MED Group. Such communications may include offers, information about services, events organised by entities from the LUX MED Group, promotions and pro-health articles. On the basis of the consent given by the Policyholder or the Insured Party, we may process personal data obtained in the course of our cooperation for marketing purposes, for example by analysing it and connecting it with other information about the Policyholder in order to adapt the communications addressed to the Policyholder to the needs of the Policyholder (Article 6(1)(a) of the Regulation).

5. The personal data may be transferred to the following categories of recipients in connection with our business activity:
   1) service providers ensuring to us technical and organisational solutions that enable us to render services and manage our organisation (in particular ICT service providers, courier and postal companies);
   2) providers of legal and advisory services and services supporting us in pursuing due claims (in particular law firms, debt collection companies);
   3) reinsurance undertakings which will be engaged in the reinsurance of the risk assumed by us under the Agreement;
   4) Medical Facilities or Hospitals.
6. As part of the Hospital Service provision process, medical records of the Insured Party provided to us or obtained by us on the basis of their consent from the relevant healthcare entities may be made available by the Insurer to Medical Facilities or Hospitals through the Hospital Care Coordinator, who assists the Insured Party in the process of: qualification for hospital treatment, the course of Hospitalisation and treatment after a stay in hospital. The process referred to in the preceding sentence shall apply to Hospital Services referred to in Appendices No 3, 4 and 5 to the GTCI.
7. On account of the fact that we use services of other providers, e.g. ICT structure services, Policyholder's and Insured Parties' personal data may be transferred outside the European Economic Area (which is composed of the EU Member States, Iceland, Norway and Liechtenstein). We assure you that in such an event the data will be transferred on the basis of relevant legal grounds, for example an agreement concluded between us and that entity, containing standard personal data protection clauses adopted by the European Commission, or on the basis of the European Commission's adequacy decision pertaining to personal data protection. We verify whether personal data is processed securely by the service provider to which it is transferred.
8. One of the ways we process personal data is the so-called profiling. It consists in our creating preference profiles based on the information about the Policyholder and the Insured Party, and therefore, based on it, customising our services and the content they receive from us. We assure you that we do not process personal data fully automatically and without human intervention.
9. We store personal data for the duration of the Agreement and then for 6 years after the expiry or termination of the Agreement. If we have processed data in order to pursue our claims (e.g. under debt collection proceedings), we process the data for the period of limitation of claims, in accordance with the provisions of the Civil Code. All tax data and data processed for accounting purposes is processed by us for 5 years from the end of the calendar year in which the tax obligation arose. If the Policyholder and the Insured Party have consented to the processing of data for marketing purposes, we process the data from the time of your consent until it is revoked. At the end of the aforementioned periods, personal data shall be erased or anonymised.
10. Concluding the Agreement with us is fully voluntary, however, as the Insurer, we are obliged to identify the Policyholder and the Insured Parties, and to perform an insurance risk assessment using personal data. Failure to provide data may result in refusal to conclude an Agreement or to provide Services. Also for accounting and tax reasons, we have a legal obligation to process data. Failure to provide them may result, e.g., in failure to issue an invoice or a personal bill. If we receive a phone number from the Policyholder or the Insured Party, this is voluntary. The absence of this data does not affect the conclusion of the Agreement but it will make it much more difficult for us to contact the eligible person in the process of executing the Agreement. Giving any marketing consent is also voluntary. This means that the refusal to provide them does not affect the use of our Services. The Policyholder and the Insured Party shall have the right to revoke their consent at any time.
11. As a data controller, we provide the Policyholder and the Insured Party with the right of access to their

LMG Försäkrings AB S.A. Branch in Poland
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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
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Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
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data. The Policyholder and the Insured Party may also rectify them, request their erasure or restrict their processing. They can also object to the processing of their personal data and to transferring of their data to another data controller. In order to exercise these rights, please contact us via the hotline, the website or our Data Protection Officer. Also, please be advised the Policyholder and the Insured Party have the right to file a complaint with the authority supervising compliance with personal data protection regulations.

§16 How can a complaint be lodged?

1. Complaints related to the conclusion or performance of the Agreement may be filed by: the Policyholder, the Insured Party or an heir having legal interest in declaration of liability or provision of Service under the Insurance Agreement:
   1) in electronic form:
      a) to the following e-mail address: reklamacje.ubezpieczenia@luxmed.pl;
      b) via the form available at https://www.luxmed.pl/zgloszenie-reklamacji-ubezpieczenia;
   2) in writing:
      a) by sending to the address of our office: LMG Försäkrings AB S.A. Branch in Poland, 02-678 Warsaw, ul. Szturmowa 2;
      b) by personal delivery of a written complaint to our registered office;
   3) orally to the written record:
      a) by calling: 22,501 81 60;
      b) by visiting our premises personally.
2. A complaint should be addressed to us and contain a brief description of the irregularities, which will allow to identify the event covered by the complaint and to determine all relevant circumstances.
3. We will respond in writing or by e-mail if the complainant so requests, no later than within 30 days from the date of receipt of the complaint.
4. In particularly complex cases, we may need more time to process a complaint. In such a situation, before the expiry of the time limit for responding to the complaint:
   1) we will explain the reason for the delay;
   2) we will indicate the circumstances which must be further ascertained in order to consider the case;
   3) we will determine the expected time limit for handling the complaint and providing a reply, which shall not exceed 60 days from the date of receipt of the complaint.
5. After exhausting the complaint procedure, the complainant shall have the right to submit a request for examination of the case by an entity authorised to settle out-of-court disputes, i.e. the Financial Ombudsman (for details, please refer to the Financial Ombudsman's website: https://rf.gov.pl/).

§17 Final provisions

1. The applicable law constituting the basis for relations between us and the Policyholder prior to the conclusion of the Agreement and the applicable law for the conclusion and performance of this Agreement shall be the Polish law. In matters not covered by the GTCI, the provisions of law generally applicable in the territory of the Republic of Poland shall apply.
2. The language used in the Insurer's relations with the Policyholder shall be Polish.
3. An action for a claim under the Agreement may be brought under the provisions on general jurisdiction or before a court competent for:
   1) the place of residence of the Policyholder, or

2) the place of residence of the Insured Party, or

3) the place of residence of the Insured Party's heir.

4. Requests, representations and notices to us that relate to the performance of the Agreement concluded under these GTCI, may be sent to:

   1) at: LMG Försäkrings AB S.A. Branch in Poland, 02-678 Warsaw, ul. Szturmowa 2;

   2) electronically to the following e-mail address: ubezpieczenia@luxmed.pl.

5. Any amendments to the Agreement shall be made in writing, electronically or documented, otherwise being null and void.

6. Claims for the Services under the Agreement may not be assigned within the meaning of Article 509 of the Act of 23 April 1964 (the Civil Code) or pledged within the meaning of Article 327 of the Civil Code.

7. We are subject to supervision by the Polish Financial Supervision Authority as regards compliance of the activities with the provisions of Polish law. The sole supervision over our financial management is exercised by the Swedish regulator.

8. The General Conditions for Individual Health Insurance - PROMED (CODE OI/3PRONH1) have been approved by a resolution of the Board of Directors of the Insurer and apply to Insurance Contracts concluded on or after 16 December 2024.

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