

GENERAL TERMS AND CONDITIONS

Additional PZU Na Życie Plus packages Cancer Support



Contens

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**INSURANCE PRODUCT INFORMATION DOCUMENT
AND GENERAL TERMS AND CONDITIONS
OF GROUP INSURANCE PZU NA ŻYCIE PLUS**



GROUP LIFE INSURANCE PZU NA ŻYCIE PLUS

Condition code: TWGP55

Version dated: 20.11.2021

This is the key information material. Full details of the insurance can be found in other documents, in particular in the general conditions of the General Terms and Conditions of Group Insurance PZU Na Życie Plus, conditions code: TWGP55 (GTC). Please read the GTCs before deciding to conclude the agreement. The definitions used in the GTCs can have meanings that deviate from their common meanings, so please make sure to pay particular attention to them. The conclusion of the agreement is voluntary.

PRODUCT INFORMATION

- is an information material,
- is not part of the insurance agreement (agreement),
- does not constitute a trade offer within the meaning of article 66 of the Civil Code,
- should not be the sole grounds for taking the decision on executing the agreement.

THE SCOPE AND OBJECT OF INSURANCE – WHAT IS INSURED?

We insure the life of the insured.

Coverage includes the death of the insured during the period of our cover.

PRODUCT CHARACTERISTICS – WHAT ARE THE MAIN FEATURES OF OUR INSURANCE?

In the event of the death of the insured, we pay a benefit to the beneficiary equal to a percentage of the sum insured current at the date of death. If the insured has named several beneficiaries and some of them die before the insured's death or lose their right to the benefit, then their share of the benefit will be distributed proportionally among the remaining beneficiaries. If the insured has not named a beneficiary or if all beneficiaries have died before the death of the insured or have forfeited their right to the benefit, then the benefit is due to the following family members of the insured in order of priority:

- spouse in full,
- children in equal parts,
- parents in equal parts,
- all legal successors to the insured in equal parts.

This is a primary insurance agreement. It is possible to extend the coverage to additional accident and sickness risks by concluding appropriate ancillary contracts.

WHO CAN CONCLUDE AN AGREEMENT WITH US, WHO DO WE INSURE?

The insurance agreement is concluded by the policyholder who pays the insurance premiums.

The Policyholder is allowed to enter into an agreement with us including several variants of insurance. The agreement defines who can joint the particular variants of the insurance.

You can join the insurance according to the insurance options in force in the contract if, on the date you sign the declaration of joining:

- you have a legal relationship with the policyholder and you are over 16 and under 69 years of age, or
- you are the spouse of the primary insured and you are over 16 years of age and under 69 years of age, or you are the life partner of the primary insured and you are over 18 years of age and under 69 years of age, or
- you are the adult child of the primary insured and are under 69 years of age and
- you declare that you are not on sick leave, in hospital, in a hospice, in an institution for the chronically ill, on rehabilitation benefits and that you are not a person declared unfit for work or unfit for uniformed service on the basis of a decision of a competent authority according to social insurance or social security regulations.

You can join the insurance if, on the date on which you sign the declaration of accession, you are a person deemed unfit to perform work in accordance with your qualifications or unfit for uniformed service on the basis of a certificate from a competent authority and:

- you have a legal relationship with the policyholder and are admitted to work by an occupational physician, or
- you are a natural person who carries out a business activity.

As a close insured who immediately prior to joining the insurance:

- has not been covered by another of our group life insurance policies, or
- has been covered by our other group life insurance policies for less than 12 months without any continuity of cover, or
- has been covered by out group life insurance for at least 12 months, however without maintaining the continuity of the insurance coverage,

You can join the insurance, if on the day of signing the declaration of membership; you file in the additionally required declaration of your health status.

Before joining the insurance you submit to the policyholder a signed declaration of membership. If the contract includes several insurance variants, you can only join one insurance variant.

WHAT IS THE DURATION OF THE INSURANCE?

The contract is concluded between PZU Życie SA and the policyholder for a fixed period. We confirm the duration of the additional insurance in the policy. The contract renews for the next policy year automatically – under the same conditions. In this case, as an insured, you do not have to re-submit the declaration of membership.

WHAT LOCATION DOES THE INSURANCE COVER?

The insurance cover operates worldwide, 24 hours a day.

HOW AND WHEN SHOULD THE CONTRIBUTIONS BE PAID?

The Policyholder pays for the premiums for all the insured at a monthly basis. The deadline for payment of the premium is specified in the contract application and the policy.

WHEN DOES THE INSURANCE COVERAGE BEGIN AND END?

Provided that you meet the conditions for taking out insurance as set out in the GTC, our cover in respect of you starts from the first day of the month following the month in which:

- we have received your signed declaration of adherence in which you agree to be covered in accordance with the terms and conditions agreement, including the amount of the sum insured,
- we received from the policyholder a list of insured who signed the declarations of membership and you are included in the list, however, no earlier than the date on which we conclude the contract with the policyholder. The date of commencement of cover is indicated on the individual confirmation of insurance.

If you are the primary insured, our insurance protection against you ceases:

- from the date on which we receive the policyholder's declaration that he or she is withdrawing from the agreement,
- upon your death,
- at the end of the month in which the legal relationship you had with the policyholder ceased (e.g. your employment contract ended); if we receive a premium for a subsequent month, our cover ends at the end of that subsequent month,
- upon the end of the month preceding the policy anniversary in the calendar year in which you turn 70,
- on the last day of the month in which you resign from our insurance protection,
- at the end of the month of the applicability of the insurance contract on the current terms and conditions, if they have not given the required consent to change the insurance;
- the expiry of the term of the supplementary insurance agreement in the event of non-renewal,
- on the date on which the period of notice specified in the GTC expires,
- at the end of the first month for which all premiums have not been received – if the policyholder fails to remit the outstanding premium on time in the situation referred to in the GTC,
- in the existing insurance option – upon the beginning of your coverage in another insurance variant.

If you are the close insured, our insurance protection against you ceases:

- on the date of termination of our cover in respect of the primary policyholder of whom you are the spouse or life partner or the adult child,
- from the date on which we receive the policyholder's declaration that he or she is withdrawing from the agreement,
- upon your death,
- on the date of death of the primary insured, of whom you are the spouse or life partner or an adult child,
- at the end of the month in which the legal relationship between the primary insured and the policyholder ceased; if we receive a premium for a subsequent month, our coverage ends at the end of that subsequent month;
- upon the end of the month preceding the policy anniversary in the calendar year in which you turn 70,
- on the last day of the month in which you resign from our insurance protection,
- at the end of the month of the applicability of the insurance contract on the current terms and conditions, if they have not given the required consent to change the insurance,

- the expiry of the term of the supplementary insurance agreement in the event of non-renewal,
- on the date on which the period of notice specified in the GTC expires,
- at the end of the first month for which all premiums have not been received – if the policyholder fails to remit the outstanding premium on time in the situation referred to in the GTC,
- in your current variant of insurance – on the day of commencement of cover in respect of you under another variant of the insurance,
- on the last day of the month in which we received notification of the dissolution of the marriage to the primary insured,
- on the last day of the month in which the primary insured person designated a new life partner or resigned from identifying you as a life partner.

MAIN EXCLUSION AND PROTECTION LIMITS– WHAT IS EXCLUDED FROM THE INSURANCE?

We are not responsible for the consequences of circumstances that you have not made known to us. If you have not deliberately made known to us all the circumstances known to you which we have asked about in your declaration of enrolment or other letter, prior to your enrolment, then in case of doubt, the event covered and its consequences shall be assumed to be the result of these circumstances. If an event covered by us occurred more than three years after you joined the insurance, we cannot claim that you provided false information when you joined the insurance.

We will not pay the benefit in the event of:

- failure to provide documents necessary to determine the validity of the claim as far as we are unable to establish our liability or the amount of the benefit on the basis of other evidence,
- the death of the insured person if it is caused by the suicide of the insured person – committed within 2 years from the beginning of the period of protection.

In addition, we are not liable if a situation is not covered, it does not meet the definition set out in the agreement or our liability has ended (e.g. due to non-payment of premiums as well as in other cases indicated in the GTC).

HOW TO TERMINATE THE AGREEMENT?

The policyholder may withdraw from the insurance contract within 30 days of the conclusion of the contract, or, if the policyholder is a trader, within seven days of the conclusion of the contract. After this period, the policyholder has the right to terminate the agreement by a written notice. The Policyholder may choose not to renew the contract by giving us written notice of non-renewal at least 30 days before the end of the contract.

REMUNERATION FOR THE DISTRIBUTOR OF THE INSURANCE

The distributor shall receive a commission in connection with the proposed agreement.

COMPLAINTS, OBJECTIONS AND GRIEVANCES

1. A claim, complaint or grievance shall be submitted to any of our units where we serve our customers.
2. A complaint, grievance or complaint can be submitted:
 - 1) in writing – in person or by mail, within the meaning of the Postal Law Act, for example by writing to the following address:
PZU Życie SA 18A Postępu St., 02-676 Warsaw (address for correspondence only);
 - 2) in writing – sent to the address for electronic delivery of PZU Życie SA, within the meaning of the Electronic Delivery Act, from the date of entering that address into the database of electronic addresses,
 - 3) verbally – by phone, for instance by calling the telephone helpline on 801 102 102, or in person, confirmed by means of a protocol during a visit to our unit;
 - 4) electronically – by sending an e-mail to reklamacje@pzu.pl or by filling in the form at www.pzu.pl.
3. We respond to complaints, grievances and complaints as soon as possible, however no later than 30 days after the day on which we receive them. If we are unable to respond in particularly complex cases within 30 days, we will inform you:
 - 1) why the response is delayed;
 - 2) what circumstances we still need to establish in order to process the case;
 - 3) what is the new time limit for our response – it may not exceed 60 days from the date on which we received the complaint, claim or grievance.
4. We respond to complaints, claims and grievances to the person who made them:
 - 1) in cases where the customer is a natural person – in writing, except that the response may be delivered by e-mail only at the customer's request;
 - 2) where the customer is an entity other than those referred to in item 1 – in writing or using another durable medium.
5. If, after the complaint has been investigated:
 - 1) we have not honoured the claims made or

- 2) we have accepted the claim, but within the time limit specified in the reply to that claim we have not carried out the acts we obliged to take
- the individual who has made a complaint has the right to write to the Financial Ombudsman to request this.
6. We deal with complaints, grievances and complaints in our units, which have jurisdiction over the subject matter.
 7. Additional information on complaints are provided in the Act on Complaints Handling by Financial Market Entities and Financial Ombudsman and in the Act on Insurance Distribution.
 8. PZU provides for the possibility of resolving conflicts out of court.
 9. The entity authorized within the meaning of the Act on out-of-court handling of consumer disputes, competent for PZU Życie SA to handle disputes out of court is the Financial Ombudsman. The website address: rf.gov.pl.
 10. In the event that the insured or the policyholder, beneficiary and the rights holder are consumers, they can turn to the Municipal and District Consumer Ombudsmen for assistance.
 11. PZU communicates with its consumers in Polish.
 12. PZU is supervised by the Financial Supervision Authority.



**GENERAL TERMS
OF GROUP INSURANCE PZU NA ŻYCIE PLUS**

In the table below, we set out the provisions of the general terms and conditions of PZU Na Życie Plus group insurance, terms and conditions code TWGP55 (GTC), which govern the exclusion and limitation of the insurance company's liability. These provisions constitute a part of the GTC, and their indications are a result of the legal regulations (Article 17, section 1 of the Insurance and Reinsurance Act).

No.	Type of information	Record number
1.	Conditions for benefit payment	item 1 items 3–4 items 13–15 items 62–65 items 66–71
2.	Restrictions and exemptions of an insurer's liability granting the right to refuse or reduce the payment of benefits	item 1 items 5–10 items 11–12 item 26 items 28–29 item 37 items 38–39 item 63

Information about the insurance are available from:

 at pzu.pl



at the phone number 801 102 102
(charged according to the operator's tariff)

GENERAL CONDITIONS OF PZU GROUP INSURANCE NA ŻYCIE PLUS

GTC code: TWGP55



The Board of Directors of PZU Życie SA established the general terms and conditions of group insurance PZU Na Życie Plus by Resolution No. UZ/202/2021 of 9 November 2021 (hereinafter referred to as GTC).

These General Terms and Conditions shall enter into force on 01 December 2021 and shall apply to insurance agreements concluded from 1 January 2022.

The policyholder shall read the GTC carefully before concluding the contract and communicate the GTC to anyone who wishes to take out insurance.

Please read the GTC you have received from your policyholder carefully before you take out insurance.

GLOSSARY

– i.e. what do the terms in the GTC actually mean

1. the GTC uses the following terminology:

- 1) **continuity of protection** – no break between the period for which the last premium was paid for the insured in the hitherto group life insurance in PZU Życie and the period for which the first premium for that insured was paid for that agreement, and in the case of change of insurance variant – no break between the period for which the last premium for the insured in the hitherto insurance variant was paid and the period for which the first premium for that insured was paid in the new insurance variant. Lack of interruption means that in the existing group life insurance in PZU Życie or insurance variant, the coverage for the insured ends on the last day of the month and from the first day of the following month, the coverage in this agreement or in the new insurance variant begins;
- 2) **external factor** – any factor which comes from outside the body of the person involved in the accident and which, under the given conditions, is likely to produce harmful effects on that person;
- 3) **declaration** – a paper form or an online form from the myPZU website, in which you declare that you want to:
 - a) join the insurance (declaration of accession) or,
 - b) change the insurance option or change the data previously provided to PZU Życie (declaration of change);
- 4) **medical records** – records that contain a description of a medical condition or of the health services provided, made by healthcare providers, health professionals and other persons involved in the provision of health services;
- 5) **the day you join the insurance** – the day on which our cover begins in respect of you (subject to the grace provisions);
- 6) **individual insurance confirmation** – a document that confirms the terms of your insurance;
- 7) **grace period** – the period during which we are not liable for an insured event;
- 8) **us/PZU Życie SA/policyholder** – Powszechny Zakład Ubezpieczeń na Życie Spółka Akcyjna;
- 9) **personal accident** – an even, which:
 - a) happens quickly and unexpectedly and
 - b) is caused by an external factor, and
 - c) it is the sole and direct cause of the event covered by the insurance, and
 - d) does not depend on the will or state of health of the person who has suffered the accident;
- 10) **insurance protection period** – the period of time during which our liability to you continues (subject to the provisions on grace periods);
- 11) **life partner** – a person who is cohabiting with the insured; and:
 - a) is not a relative of the insured,
 - b) is not married and
 - c) the insured indicated it in his declaration.

A life partner who is named in the declaration of the primary insured or the insured adult child and does not submit his or her own declaration of adherence – is not an insured.

A life partner who is named in the declaration of the primary insured and makes a separate declaration of adherence – is an insured relative.

The designation of a life partner is effective from the first day of the month following the month in which the insured person designated a life partner. The insured can only designate a life partner if he or she is not married himself or herself. The insured may change the life partner named in the declaration once in each policy year.
- 12) **adult child** – child:
 - a) the primary insured,

- b) the spouse or a life partner of the primary insured,
– who is at least 18 years old;
- 13) **an establishment for the chronically ill** – an entity providing round-the-clock, in-patient long-term care and nursing services: a nursing home, residential care home or 24-hour care facility established under the relevant legislation;
- 14) **signing the declaration** – the application of a handwritten signature to the content of the declaration, or the application of a declaration of intent to the content of the declaration in another form, to which the parties agree, by a person authorised to do so;
- 15) **policy** – a document which confirms the conclusion of the agreement and its terms;
- 16) **performance** – the payment of a cash benefit to the insured or beneficiary or the provision of a service to the insured in the event of an event covered by our protection;
- 17) **policy anniversary** – each anniversary of the date on which the agreement was concluded;
- 18) **policy year** – any period of 12 consecutive months of the agreement beginning on the date of the agreement or on each policy anniversary and ending on the last day of the twelfth month following the date of the agreement or the policy anniversary;
- 19) **Service mojePZU** – an online service available via the moje.pzu website or mobile application, which enables access to insurance information, contact with PZU Życie and use of the services listed in the Terms and Conditions for the provision of electronic services of the mojePZU Website;
- 20) **legal relationship** – employment agreement, agreement of mandate, agreement of work, agency agreement, agreement, appointment, or any other legal relationship between the policyholder and the primary insured that we accept;
- 21) **party to the agreement** – PZU Życie, the policyholder;
- 22) **You/insured** – a natural person who joined the insurance and::
 - a) it has a legal relationship with the policyholder (primary insured),
 - b) is the spouse or life partner or the adult child of the primary insured (relative insured);
- 23) **policyholder** – an entity which entered into an agreement with PZU Życie;
- 24) **basic insurance** – PZU Na Życie Plus group insurance agreement, to which the policyholder has the right to take out additional insurance;
- 25) **supplementary insurance** – an insurance agreement by which the primary insurance may be extended;
- 26) **agreement** – an agreement of group insurance concluded by the contracting parties at the request of the policyholder, consisting of either primary insurance or primary and supplementary insurance;
- 27) **beneficiary** – the natural person or other legal entity designated by the insured person as entitled to receive a benefit in the event of the death of that insured person;
- 28) **beneficiary** – the person who, in certain situations, may claim payment of the cash benefit, i.e. the beneficiary, the heir of the insured, the person mentioned in point 65 of the GTC, the heirs of these persons;
- 29) **insurance option(s)** – the coverage chosen by the policyholder, as confirmed by the policy.

OBJECT OF INSURANCE

– what do we insure

- 2. We insure your life.

SCOPE OF INSURANCE AND THE BENEFIT AMOUNT

– which events do we pay for and what amounts

- 3. Coverage includes the death of the insured during the period of cover.
- 4. If the insured dies during the period of cover, we will pay a benefit equal to a percentage of the sum insured current at the date of death, which is specified in the policy and in the individual confirmation of insurance

GRACE PERIOD

– i.e. for what period after your enrolment in the insurance we have no or limited liability

- 5. In the cases described in points 6–9 of the GTC, a grace period applies during the first 6 months counted from the date you join the insurance. However, we are liable if the death occurred as a result of an accident during the grace period.
- 6. If you are the primary insured, a grace period applies to you if the date you join the supplementary insurance is more than 4 months after the date:
 - 1) the conclusion of the agreement – provided that you had a legal relationship with the policyholder on the date of conclusion of the contract;
 - 2) the creation of the legal relationship with the policyholder – as far as it commenced after the date of conclusion of the contract.
- 7. If you are the spouse of the primary insured (insured relative), the grace period applies to you when the date you join the supplementary insurance is more than 4 months after the date:
 - 1) the conclusion of the agreement – as far as the primary insured had a legal relationship with the policyholder on the date of conclusion of the agreement;

- 2) the commencement of the legal relationship of the primary insured with the policyholder – as far as it commenced after the day of executing the agreement;
- 3) marrying the primary insured after concluding the supplementary insurance.
8. If you are the life partner of the primary insured (insured relative), the grace period applies to you if the date you join the supplementary insurance exceeds 4 months after the date:
 - 1) the conclusion of the agreement – as far as the primary insured had a legal relationship with the policyholder on the date of conclusion of the agreement;
 - 2) the commencement of the legal relationship of the primary insured with the policyholder – as far as it commenced after the day of executing the agreement;
9. If you are the adult child of the primary insured (insured relative), the grace period applies to you when the date you join the supplementary insurance is more than 4 months after the date:
 - 1) the conclusion of the agreement – as far as the primary insured had a legal relationship with the policyholder on the date of conclusion of the agreement;
 - 2) the commencement of the legal relationship of the primary insured with the policyholder – as far as it commenced after the day of executing the agreement;
 - 3) your reaching the age of 18, if this took place after the conclusion of the contract.
10. In the case of a change of insurance option with the same policyholder, with continuity of coverage, the grace period applies to the amount of the difference between the current and previous benefit amount and to the difference in coverage. The grace period is specified in the basic insurance (section 5 of the GTC) and the additional insurances. The grace period does not apply if the incident was caused by an accident.

EXCLUSIONS OF PROTECTION

– cases in which we are not going to pay out the benefit

11. We use the following terms for the purpose of defining exclusions to our protection:
 - 1) acts of terror – are individual or group acts against the population or property in order to achieve economic, political or social effects by creating chaos, intimidating the population, disorganising public life, the functioning of public transport, service or production facilities;
 - 2) war operations – actions of armed forces aimed at breaking down enemy forces on land, in the air or at sea;
 - 3) mass social unrest – these are speeches by a social group against the structures that exercise power under the law, caused by dissatisfaction with the political, economic or social situation; mass social unrest is usually accompanied by acts of physical violence.
12. We are not liable for the death of the insured if it occurs:
 - 1) during war operations;
 - 2) as a result of an active participation in acts of terror or mass social unrest;
 - 3) as a result of the commission or attempted commission by the insured of an act which fulfils the requirements of an intentional crime;
 - 4) as a result of the insured's suicide – committed within 2 years of the start of the cover period;
 - 5) as a result of a traffic accident – if the Insured drove the vehicle while intoxicated within the meaning of the provisions on upbringing in sobriety and counteracting alcoholism or after using: drugs, narcotics, psychotropic substances or substitute substances within the meaning of the provisions on counteracting drug addiction – provided that any of these circumstances had an impact on the traffic accident.

SUM INSURED

– what is it, and where is it indicated

13. The sum insured is the amount which we use as the basis for determining the benefit due.
14. The amount of the sum insured can be included in the policy and in the individual confirmation of insurance.
15. The sum insured does not change throughout the duration of the agreement. The sum insured is fixed, but may be changed by mutual agreement;

PREMIUM

– what it depends on, when to pay it and the consequences of not paying it

16. Amount of the premium per the insured:
 - 1) we specify in the agreement application and confirm in the policy;
 - 2) takes into account the grace periods that apply in supplementary insurance;
 - 3) it is fixed, but may be changed by mutual agreement;
 - 4) it depends on:
 - a) the sum insured,
 - b) insurance coverage,
 - c) benefit amount
 - d) the number, age structure and gender of those who take out insurance, as well as the type of work they do.

17. The Policyholder pays for the premiums for all the insured at a monthly basis. The deadline for payment of the premium is specified in the contract application and the policy.
18. We consider the contribution to have been paid when it is received in the bank account we have indicated.
19. If you are in arrears with your contribution, we will allocate any payment to cover these arrears in the first instance.
20. If the premium is not paid on time:
 - 1) we will call on the policyholder to pay it within 7 days of receiving the call. The notice will inform the policyholder of the effect of failure to pay the premium on time, i.e. the suspension of cover in respect of all policyholders and the maximum period of suspension. We can suspend protection for a maximum period of two months calculated:
 - a) from the first day of the month following the month in which the agreement was concluded, in the event of overdue payment of the first contribution, or
 - b) from the first day of the month following the month for which no further contribution has been received – if no further contribution has been paid;
 - 2) after the expiry of the deadline for payment of the premium indicated in the summons referred to in subsection 1 to no avail, we will again summon the policyholder to pay the premium within 7 days of the receipt of our summons by the policyholder. In the summons, we will inform the policyholder of the effect of non-payment of the premium by the due date, i.e. the agreement will be deemed terminated by the policyholder with effect from the date of expiry of the second month of non-payment of the outstanding premium, but no later than the end of the agreement period.
The effect of the agreement being deemed to have been terminated by the policyholder will not take place if the policyholder has paid the entire outstanding premium before its due date.

CONCLUSION OF THE AGREEMENT

– what is required for that purpose

21. The policyholder will receive the GTC and the necessary forms from us before entering into a agreement with us.
22. To conclude a agreement with us, the policyholder submits:
 - 1) application to conclude a agreement;
 - 2) accession declarations signed by those who wish to take out insurance;
 - 3) a list of persons who have signed a declaration of accession;
 - 4) other documents, as far as they are necessary for the conclusion of the agreement under the law.
23. We have the right to refuse to conclude a agreement.
24. We confirm the conclusion of the contract with a policy.
25. The Policyholder is allowed to enter into an agreement with us including several variants of insurance. The agreement defines who can join the particular variants of the insurance.

JOINING THE INSURANCE

– who we insure and how do we insure

26. You can join the insurance according to the insurance options in force in the contract if, on the date you sign the declaration of joining:
 - 1) you have a legal relationship with the policyholder and you are over 16 and under 69 years of age, or
 - 2) you are the spouse of the primary insured and you are over 16 years of age and under 69 years of age, or you are the life partner of the primary insured and you are over 18 years of age and under 69 years of age, or
 - 3) you are the adult child of the primary insured and are under 69 years of age and
 - 4) you declare that you are not on sick leave, in hospital, in a hospice, in an institution for the chronically ill, on rehabilitation benefits and that you are not a person declared unfit for work or unfit for uniformed service on the basis of a decision of a competent authority according to social insurance or social security regulations – subject to items 27–31 of the GTC.
27. You can join the insurance if, on the date on which you sign the declaration of accession, you are a person deemed unfit to perform work in accordance with your qualifications or unfit for uniformed service on the basis of a certificate from a competent authority and:
 - 1) you have a legal relationship with the policyholder and are admitted to work by an occupational physician, or
 - 2) you are a natural person who carries out a business activity.
28. As a close insured who immediately prior to joining the insurance:
 - 1) has not been covered by another of our group life insurance policies, or
 - 2) has been covered by our other group life insurance policies for less than 12 months without any continuity of cover, or;
 - 3) has been covered by out group life insurance for at least 12 months, however without maintaining the continuity of the insurance coverage,

You can join the insurance, if on the day of signing the declaration of membership; you file in the additionally required declaration of your health status.
29. Before joining the insurance you submit to the policyholder a signed declaration of membership. If the contract includes several insurance variants, you can only join one insurance variant.
30. If you do not meet the conditions for taking out insurance as indicated in the GTC – you will not be covered.
31. Regardless of meeting the conditions for taking out insurance as set out in the GTC – we may refuse to cover you. We communicate the refusal to the policyholder.
32. If we receive an amount towards the premium for a person who has not fulfilled the conditions for taking out insurance as set out in the GTC or for a person who is refused coverage, we are obliged to return it to the policyholder.

33. You are obliged to make known to us all circumstances known to you which we ask about in the declaration of accession or in any other letter before you join the insurance.
34. We shall not be liable for the consequences of circumstances which, in violation of clause 33 of the GTC, you have not made known to us. If you have not deliberately made known to us all the circumstances known to you which we have asked about in your declaration of enrolment or other letter, prior to your enrolment, then in case of doubt, the event covered and its consequences shall be assumed to be the result of these circumstances. If an event covered by us occurred more than three years after you joined the insurance, we cannot claim that you provided false information when you joined the insurance.
35. If the agreement covers several insurance variants, you may give us a declaration of intent to change the insurance variant at any time during the term of the agreement (with the proviso that coverage under the new insurance variant will commence with respect to the You from the first day of the month following the month in which we received your declaration concerning the change of insurance option), unless otherwise stated in the general terms and conditions of supplementary insurance.
36. PZU Życie, in order to enable the Insured to perform the activities related to the insurance agreement remotely, provides the myPZU Service. Upon joining the (agreement of) group insurance, the insured will receive a one-time password and login to myPZU. Using myPZU is possible after logging in and accepting the Regulations of myPZU by the insured person. The one-time password expires 3 days after receipt. Once the one-time password has expired, setting up an account on the myPZU is possible under the conditions described at <https://moje.pzu.pl>. The use of myPZU is voluntary and free of charge.

THE BEGINNING OF OUR PROTECTION

– i.e. when our insurance protection starts

37. Subject to points 5 to 10 of the GTC and provided that you meet the conditions for taking out insurance as set out in the GTC, our cover in respect of you shall commence on the first day of the month following the month in which:
 - 1) we have received your signed declaration of adherence in which you agree to be covered in accordance with the terms of the agreement, including the sum insured;
 - 2) we received from the policyholder a list of insured who signed the declarations of membership and you are included in the list,however, no earlier than the date on which we conclude the contract with the policyholder. The date of commencement of cover is indicated on the individual confirmation of insurance.

THE CESSATION OF OUR PROTECTION

– when the supplementary insurance ends

38. If you are the primary insured, our insurance protection against you ceases:
 - 1) from the date on which we receive the policyholder's declaration that he or she is withdrawing from the agreement;
 - 2) upon your death;
 - 3) at the end of the month in which the legal relationship you had with the policyholder ceased (e.g. your employment contract ended); if we receive a premium for a subsequent month, our cover ends at the end of that subsequent month;
 - 4) upon the end of the month preceding the policy anniversary in the calendar year in which you turn 70;
 - 5) on the last day of the month in which you resign from our insurance protection;
 - 6) by the end of the month of applicability of the agreement on the current rules, if the insured did not consent to amend the agreement, in the case specified in item 41 of the GTC;
 - 7) the expiry of the term of the supplementary insurance agreement in the event of non-renewal;
 - 8) on the date on which the period of notice specified in clause 55 of the GTC expires;
 - 9) at the end of the first month for which all premiums have not been received – if the policyholder fails to remit the outstanding premium on time in the situation referred to in item 57 in conjunction with item 20(2) of the GTC;
 - 10) in the existing insurance option – upon the beginning of your coverage in another insurance variant.
39. If you are the close insured, our insurance protection against you ceases:
 - 1) on the date of termination of our cover in respect of the primary policyholder of whom you are the spouse or life partner or the adult child;
 - 2) from the date on which we receive the policyholder's declaration that he or she is withdrawing from the agreement;
 - 3) upon your death;
 - 4) on the date of death of the primary insured, of whom you are the spouse or life partner or an adult child,
 - 5) at the end of the month in which the legal relationship between the primary insured and the policyholder ceased; if we receive a premium for a subsequent month, our coverage ends at the end of that subsequent month;
 - 6) upon the end of the month preceding the policy anniversary in the calendar year in which you turn 70;
 - 7) on the last day of the month in which you resign from our insurance protection;
 - 8) by the end of the month of applicability of the agreement on the current rules, if the insured did not consent to amend the agreement, in the case specified in item 41 of the GTC;
 - 9) the expiry of the term of the supplementary insurance agreement in the event of non-renewal;
 - 10) on the date on which the period of notice specified in clause 55 of the GTC expires;
 - 11) at the end of the first month for which all premiums have not been received – if the policyholder fails to remit the outstanding premium on time in the situation referred to in item 57 in conjunction with item 20(2) of the GTC;
 - 12) in the existing insurance option – upon the beginning of your coverage in another insurance variant.
 - 13) on the last day of the month in which we received notification of the dissolution of the marriage to the primary insured,

- 14) on the last day of the month in which the primary insured named a new life partner or resigned from naming you as a life partner.

AMENDMENTS TO THE AGREEMENT

– how they can be introduced

40. All amendments to the Agreement shall be made in writing under pain of nullity.
41. Your consent is needed to change the agreement to your or the holder's disadvantage. A statement including your consent shall be submitted to the policyholder.

SUSPENSION OF THE AGREEMENT AT THE POLICYHOLDER'S REQUEST

– when it occurs and what it means

42. At the request of the policyholder, we may suspend the agreement for a specific period during which we are not liable. The agreement suspension period always covers full calendar months.
43. Suspension of the agreement is possible if, at the date of application, the policyholder has paid all premiums due under the agreement.
44. The policyholder shall be released from the obligation to pay agreement premiums for the period of suspension of the agreement. When the suspension of the agreement ends, the policyholder shall pay the premiums as they fall due.
45. The policyholder must inform the insured persons of the intention to suspend the agreement and obtain their consent to the suspension of the agreement.
46. We are not liable for incidents covered by the agreement which occur during the period of suspension of the agreement.
47. During the period of suspension of the agreement, the grace periods applicable to policyholders under the agreement shall not be suspended.
48. The agreement shall be resumed on the first calendar day following the end of the agreement suspension period, without the application of additional (new) grace periods, subject to the need for the insured to serve grace periods that did not end during the agreement suspension.

DURATION OF THE AGREEMENT

– which period we take out the supplementary insurance for

49. The policyholder enters into a fixed-term agreement with us. We confirm the duration of the additional insurance in the policy.

RENEWAL OF THE AGREEMENT

– what are the rules for extending the duration of the agreement

50. Unless otherwise agreed by either party to the contract, the contract will renew for the next policy year automatically – under the same terms and conditions. In this case, as an insured, you do not have to re-submit the declaration of membership.
51. Either party may opt out of the renewal of a given agreement, of which it should notify the other party in writing. This must be done at least 30 days before the end of the contract.

WITHDRAWAL FROM THE AGREEMENT

– i.e. under which conditions a policyholder may withdraw from the agreement

52. The policyholder may withdraw from the agreement when they state this to us in writing:
1) within 7 days after the conclusion of the agreement – if the policyholder is a business owner.
2) within 30 days after the conclusion of the agreement – if the policyholder is not a business owner. In the event that the Policyholder, at the latest at the time of conclusion of the agreement, did not inform the Policyholder who is a consumer of his or her right to withdraw from the insurance agreement, the 30-day period starts from the day on which the Policyholder who is a consumer became aware of that right.
53. Withdrawal from the agreement does not relieve the policyholder from the obligation to pay the premium for the period during which the insurer has provided cover.
54. If the policyholder cancels the agreement after the premium has been paid, we will refund the premium reduced by the amount of the premium for the insurance protection period provided.

TERMINATION OF THE AGREEMENT

– i.e. the manner in which the policyholder can cancel the supplementary insurance

55. The Policyholder may terminate the agreement at any time without giving any reason, subject to three months' notice. The notice of termination should be given in writing.

56. In the case referred to in item 55, the agreement shall terminate at the end of the calendar month in which the three-month notice period expires.



EXAMPLE

If notice of termination is received on 25 August, the agreement terminates on 30 November. During the notice period, the policyholder is obliged to pay the premium.

57. The agreement shall be deemed to have been terminated by the policyholder in the case described in point 20(2) of the GTC.

YOUR RIGHTS AND OBLIGATIONS

– what the insured should remember about

58. You can cancel your insurance at any time if you submit your cancellation in writing to the policyholder.
59. You have a duty to notify the policyholder or us of changes to your and your beneficiaries' personal and contact details that you provided in the declaration.

OBLIGATIONS OF THE POLICYHOLDER

– i.e. what obligations shall the policyholder assume

60. The policyholder must:
- 1) serve the terms of the agreement, including the GTC, on persons taking out insurance. The Policyholder may deliver the terms and conditions of the agreement, including the GTC, in writing or on another durable medium if the person taking out insurance agrees to this. He or she should do this before the persons sign the declarations of accession;
 - 2) provide us with signed declarations of adherence on time;
 - 3) inform us immediately of any change in personal and contact details: of the policyholder, as well as of the insured, of the beneficiaries – if the insured has not previously notified us of these changes;
 - 4) inform us without delay of the occurrence in respect of the insured person of a premise which causes the termination of cover in accordance with the GTC;
 - 5) pay us the premiums for the insurance protection period provided by the date specified in the agreement application and confirmed in the policy;
 - 6) provide us with a statement of premiums by the end of the month to which the statement relates and a list of insured persons by the deadline indicated in clause 37 of the GTC;
 - 7) communicate to insured persons any change in the terms of the agreement or in the law applicable to the agreement about the impact of these changes on the value of the benefit. It shall provide this information in the form prescribed by the "Insurance and Reinsurance Business Act." The policyholder must provide the insured with this information before agreeing to such changes;
 - 8) provide us with a list of persons who have agreed to a change of agreement with respect to him in the situation referred to in clause 41 of the GTC and, at our request, provide us with the declarations referred to in clause 41 sentence 2 of the GTCs;
 - 9) at our request, provide the insured with other documents or information that are necessary for the proper execution of the agreement, including information on the refusal of coverage, the suspension of coverage, in the situation referred to in point 20 of the GTC, and information on the suspension of the agreement;
 - 10) appoint a person to be responsible for his performance of the agreement and inform the insured and us that he has appointed such a person.

OUR RESPONSIBILITIES

– i.e., responsibilities assumed by PZU Życie

61. We must:
- 1) meet our contractual obligations in a timely manner;
 - 2) communicate to the policy holder any change in the conditions of the agreement or in the law applicable to the agreement about the impact of these changes on the value of the benefit. We provide this information in the form prescribed by the "Insurance and Reinsurance Business Act." Before we and the policyholder agree to make such changes, the policyholder must provide the policyholders with this information;
 - 3) provide you, at your request, with the information referred to in point 61(2) of the GTC;
 - 4) inform you or the policyholder that events covered by our cover have occurred if we have been notified of the event by another person; this information will be provided within 7 days of receipt of the notification;
 - 5) inform the claimant, if necessary, of the documents we require in order to establish a right to benefits. We may do this in writing or by any other means to which the person has consented;
 - 6) inform in writing the person who is claiming the benefit and you, if you are not that person, of this:
 - a) why we are unable to deliver this service in whole or in part within the stipulated timeframe. We will then only realise that part of the benefit which is undisputed,

- b) if the health service is not due in total or in part. We then indicate the reasons and legal basis that justify our decision and inform you that you can pursue your claim in court;
- 7) provide information and documents which have influenced our decision on the determination of the right to a benefit or the amount thereof:
 - a) To you or
 - b) the policyholder, or
 - c) the entitled, or
 - d) another person who requests the provision of the benefit.
 We provide information and documents to these persons in electronic form upon request;
- 8) provide – on your request – information on your rights and obligations under the agreement;
- 9) make them available at the request of the policyholder or yourself:
 - a) information about the declarations made by the policyholder when he concluded the agreement,
 - b) information about the statements you made when you joined the insurance,
 - c) copies of the documents that were produced at the time.

PERSONS ENTITLED TO OBTAIN THE BENEFIT

– the person to whom the payment is due

- 62. Benefit payments are available to the beneficiaries. You are free to nominate, change or cancel them.
- 63. A benefit is not going to be paid to a person who intentionally contributed to your death.
- 64. If you name several beneficiaries and some of them die before you or lose their right to a benefit payment, then we will distribute the benefit due to them proportionally to the remaining beneficiaries.
- 65. If you do not name a beneficiary or if all beneficiaries die before you or lose their right to payment, your family members are entitled to the benefit, in order of priority:
 - 1) spouse – in full;
 - 2) children – in equal shares;
 - 3) parents – in equal shares;
 - 4) your other heirs – in equal shares.

PROVISION OF THE HEALTH BENEFIT

– when we pay the benefit

- 66. After your death, the person claiming the benefit must provide us with:
 - 1) a request for payment of a benefit,
 - 2) a death certificate;
 - 3) The certificate of death or, in cases where it is not possible to obtain, medical documentation documenting the cause of death if it was caused by an accident or occurred within the two years of our protection.
- 67. We may ask for other required documents in case those which had already been provided do not suffice to consider that a benefit payment is due.
- 68. If the documents we have requested are in a language other than Polish, the person making the request must provide us with a translation into Polish. This translation must be carried out by a sworn translator.
- 69. We decide on the payment of the benefit based on the documentation stated above.
- 70. We will pay the benefit in a single payment, no later than 30 days from the date of receipt of notice of the insured event.
- 71. If it proves impossible to clarify the circumstances necessary to establish our liability or the amount of the benefit within the aforementioned period, the benefit shall be provided by us within 14 days from the day on which it became possible to clarify those circumstances with due diligence. However, we will pay the undisputed portion of the benefit within the time limit set out in clause 70 of the GTC.

COMPLAINTS, OBJECTIONS AND GRIEVANCES

– who, where and how to submit them

- 72. A claim, complaint or grievance shall be submitted to any of our units where we serve our customers.
- 73. A complaint, grievance or complaint can be submitted:
 - 1) in writing – in person or by mail, within the meaning of the Postal Law Act, for example by writing to the following address: PZU Życie SA 18A Postępu St., 02-676 Warsaw (address for correspondence only);
 - 2) in writing – sent to the address for electronic delivery of PZU Życie SA, within the meaning of the Electronic Delivery Act, from the date of entering that address into the database of electronic addresses;
 - 3) verbally – by phone, for instance by calling the telephone helpline on 801 102 102, or in person, confirmed by means of a protocol during a visit to our unit;
 - 4) electronically – by sending an e-mail to reklamacje@pzu.pl or by filling in the form at www.pzu.pl.
- 74. We respond to complaints, grievances and complaints as soon as possible, however no later than 30 days after the day on which we receive them. If we are unable to respond in particularly complex cases within 30 days, we will inform you:
 - 1) why the response is delayed;

- 2) what circumstances we still need to establish in order to process the case;
- 3) what is the new time limit for our response – it may not exceed 60 days from the date on which we received the complaint, claim or grievance.
- 75. We respond to complaints, claims and grievances to the person who made them:
 - 1) in cases where the customer is a natural person – in writing, except that the response may be delivered by e-mail only at the customer's request;
 - 2) where the customer is an entity other than those referred to in item 1 – in writing or using another durable medium.
- 76. If, after the complaint has been investigated:
 - 1) we have not honoured the claims made or
 - 2) we have accepted the claim, but within the time limit specified in the reply to that claim we have not carried out the acts we obliged to take
 – the individual who has made a complaint has the right to write to the Financial Ombudsman to request this.
- 77. We deal with complaints, grievances and complaints in our units, which have jurisdiction over the subject matter.
- 78. Additional information on complaints are provided in the Act on Complaints Handling by Financial Market Entities and Financial Ombudsman and in the Act on Insurance Distribution.
- 79. PZU provides for the possibility of resolving conflicts out of court.
- 80. The entity authorized within the meaning of the Act on out-of-court handling of consumer disputes, competent for PZU SA to handle disputes out of court is the Financial Ombudsman. The website address: rf.gov.pl.
- 81. In the event that the insured or the policyholder, beneficiary and the rights holder are consumers, they can turn to the Municipal and District Consumer Ombudsmen for assistance.
- 82. PZU communicates with its consumers in Polish.
- 83. PZU is supervised by the Financial Supervision Authority.

FINAL PROVISIONS

– what other matters are important

- 84. The taxation rules for amounts received under an insurance agreement are governed by the “Personal Income Tax Act” and the “Corporate Income Tax Act.”
- 85. If we legally have to deduct any amounts from the benefit payment, especially income tax, the benefit payment will be reduced by these amounts.
- 86. The relationships under this agreement are governed by Polish law.
- 87. The law applicable to this agreement is Polish law.
In matters not regulated by this agreement, the following shall apply: the provisions of the Civil Code, the “Insurance and Reinsurance Business Act” and other legal provisions.
- 88. We will give all our notifications, requests and declarations that relate to the agreement in writing or in any other form that we have agreed with the policyholder. They have legal effect from the day we serve them.
- 89. All notifications, requests and declarations that relate to the agreement – except complaints, claims and grievances – must be made in writing or in another form that the policyholder has agreed with us. They have legal effect from the date on which they are served on us.
- 90. The Insured, the Policyholder and PZU Życie are obliged to inform each other of any change of address.
- 91. A suit in respect of matters arising from this agreement may be brought in accordance with the rules of general jurisdiction in accordance with the Code of Civil Procedure or:
 - 1) to the court having jurisdiction over the registered office of the policyholder or the place of residence of the insured person, or
 - 2) to the court having jurisdiction over the place of residence of the insured's heir.
- 92. We do not use a technical rate in the agreement.
- 93. We publish solvency and financial condition reports on pzu.pl in the investor relations section.



**INSURANCE PRODUCT INFORMATION DOCUMENT
AND GENERAL TERMS AND CONDITIONS
OF THE SUPPLEMENTARY GROUP INSURANCE
AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE
INSURED PERSON**



SUPPLEMENTARY GROUP INSURANCE AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON

Terms and Conditions Code: COGP56

Document version dated 22 November 2025

This document contains information about the insurance product. Full details of the insurance are provided in other documents, in particular in the General Terms and Conditions of the Supplementary Group Insurance against Serious Oncological Diseases of the Insured Person, Terms and Conditions Code: COGP56 (the GTC). Before deciding whether to enter into the insurance contract, please read the GTC carefully. Definitions used in the GTC may differ from their commonly accepted meaning; therefore, please pay particular attention to them.

The conclusion of the contract is voluntary.

THIS DOCUMENT:

- is provided for information purposes only;
- does not form part of the insurance contract (the Contract);
- does not constitute an offer within the meaning of Article 66 of the Polish Civil Code;
- should not be relied upon as the sole basis for making a decision to enter into the Contract.

SUBJECT MATTER AND SCOPE OF COVER

We insure the health of the Insured Person.

The scope of the insurance covers the occurrence, during the cover period, of an insured event affecting the insured person that meets our definition set out in the Appendix to the GTC.

PRODUCT FEATURES – THE MAIN FEATURES OF OUR INSURANCE

In the event of the Insured Person suffering a serious oncological disease, we will pay the Insured Person a benefit equal to the percentage of the Sum Insured applicable on the date of occurrence of the insured event, as specified in the policy and the individual certificate of insurance.

The Supplementary Insurance may be taken out either at the same time as the Principal Insurance (PZU Na Życie Plus Group Insurance) or during its term.

ELIGIBILITY TO ENTER INTO THE CONTRACT AND PERSONS COVERED

The Supplementary Insurance is taken out by the Policyholder, who is responsible for paying the insurance premium. The Supplementary Insurance is available to Insured Persons who have joined the Principal Insurance.

DURATION OF THE CONTRACT

The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

TERRITORIAL SCOPE OF COVER

Insurance cover applies worldwide.

PAYMENT OF PREMIUMS

Premiums are paid by the Policyholder on a monthly basis together with the premium for the principal insurance policy.

Powszechny Zakład Ubezpieczeń na Życie Spółka Akcyjna, District Court for the Capital City of Warsaw, 13th Commercial Division, KRS [National Court Register Number] 30211, NIP [Tax Identification Number] 527-020-60-56, share capital: PLN 295,000,000.00 paid in full, Rondo Ignacego Daszyńskiego 4, 00-843 Warsaw, pzu.pl, helpline: 801 102 102 (charge according to the operator's tariff)

COMMENCEMENT AND TERMINATION OF INSURANCE COVER

Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy. Cover under the Supplementary Insurance shall commence only if cover under the Principal Insurance is in force.

Insurance cover under the supplementary insurance shall terminate:

- on the date cover under the Principal Insurance terminates;
- on the date we receive the Policyholder's notice of withdrawal from the supplementary insurance;
- on the expiry date of the supplementary insurance cover, where it is not renewed;
- on the last day of the month in which you opt out of the supplementary insurance;
- at the end of the month during which the supplementary insurance remains in force on its existing terms and conditions, if you have not provided the required consent to a change in the supplementary insurance;
- on the date the notice period for termination of the supplementary insurance expires;
- on the date the supplementary insurance contract is terminated.

MAIN EXCLUSIONS AND LIMITATIONS OF INSURANCE COVER

No benefit will be payable in the following circumstances:

- if the same insured event occurs again after a benefit has already been paid in respect of a previous occurrence of that event;
- if the documents required to assess the validity of the claim are not provided, unless we are able to determine our liability or the amount of the benefit on the basis of other available evidence;
- if the insured event occurs before the commencement of our cover period.

In addition, we shall not be liable where the event concerned falls outside the scope of cover, does not meet the definition specified in the Contract, where our liability has ceased, or in any other circumstances specified in the GTC.

TERMINATION OF THE CONTRACT

The Policyholder may withdraw from the supplementary insurance contract within:

- 7 days of entering into the contract, if the Policyholder is a business undertaking;
- 30 days of entering into the contract, if the Policyholder is not a business undertaking.

After this period, the Policyholder may terminate the contract by giving written notice.

The Policyholder may elect not to renew the supplementary insurance by submitting a written declaration of non-renewal no later than 30 days before the expiry of the insurance period.

INSURANCE DISTRIBUTOR'S REMUNERATION

Under the proposed contract, the insurance distributor receives commission-based remuneration.

COMPLAINTS, GRIEVANCES AND APPEALS

1. A complaint, grievance or appeal may be submitted at any of our customer service offices.
2. A complaint, grievance or appeal may be made:
 - 1) in writing – in person or by post within the meaning of the Postal Law Act, for example by writing to: PZU Życie SA ul. Postępu 18A, 02-676 Warsaw (correspondence address only), or by submitting correspondence through a postal or delivery service provider operating within the European Union;
 - 2) in writing – by sending it to the electronic delivery address of PZU Życie SA within the meaning of the Electronic Deliveries Act: AE:PL-50066-37983-FBWRA-37, as registered in the electronic address database referred to in the Act on Electronic Delivery;
 - 3) verbally – by telephone, for example by calling our helpline on 801 102 102, or in person at one of our offices, in which case the submission will be recorded in a written report;
 - 4) electronically – by sending an email to reklamacje@pzu.pl or by completing the online form available at pzu.pl or www.moje.pzu.pl.
3. We will respond to any complaint or grievance as soon as possible and no later than 30 days from the date of receipt. In particularly complex cases, where it is not possible to provide a response within 30 days, we will inform you:
 - 1) of the reasons for the delay;
 - 2) of the circumstances that still need to be established in order to resolve the matter;
 - 3) of the revised deadline for our response, which shall not exceed 60 days from the date on which we received the complaint, grievance or appeal.
4. Responses to complaints, grievances or appeals will be provided to the person who submitted them:

- 1) where the customer is a natural person, in writing; however, the response may be provided by electronic mail solely at the customer's request;
 - 2) where the customer is an entity other than that referred to in item 1, in writing or by means of another durable medium.
5. If, following the investigation of the complaint:
- 1) we have not upheld the claims submitted; or
 - 2) we have upheld the claims but have failed to carry out, within the timeframe specified in our response, the actions we undertook to perform,
 - the individual who submitted the complaint may refer the matter to the Financial Ombudsman by submitting an application.
6. Complaints, grievances and appeals are considered by the organisational units responsible for the subject matter of the case.
7. Further information regarding complaints can be found in the Act on the Handling of Complaints by Financial Market Entities, the Financial Ombudsman and the Financial Education Fund, as well as in the Insurance Distribution Act.
8. We provide for the possibility of resolving disputes through out-of-court dispute resolution procedures.
9. For the purposes of the Act on Out-of-Court Consumer Dispute Resolution, the entity authorised to conduct out-of-court dispute resolution proceedings in relation to PZU Życie SA is the Financial Ombudsman. Financial Ombudsman's website: rf.gov.pl.
10. Where the Insured Person, the Policyholder, the Beneficiary or any entitled person is a consumer, they may also seek assistance from their municipal or district Consumer Ombudsman.
11. The language used by us in our dealings with consumers is Polish.
12. PZU Życie SA is supervised by the Polish Financial Supervision Authority (KNF).

The table below identifies the provisions of the General Terms and Conditions of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person, Terms and Conditions Code COGP56 (the GTC), which set out the principal terms of the insurance contract.

This information forms part of the GTC and is provided pursuant to statutory requirements (Article 17(1) of the Insurance and Reinsurance Activity Act).

Item	Type of information	Clause reference
1.	Conditions for benefit payment	Clauses 1–2 Clauses 4–5 Clauses 13–15 Clause 33 Clauses 34–39 Clause 40
2.	Limitations and exclusions of the insurer's liability entitling it to refuse payment of benefits or to reduce the amount payable	Clauses 1–2 Clauses 6–10 Clauses 11–12 Clauses 30–31 Clause 32 Clause 40



GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON



GTC Code: COGP56

The Management Board of PZU Życie SA adopted these General Terms and Conditions of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person by Resolution No. UZ/165/2025 dated 14 October 2025 (hereinafter referred to as the GTC).

These GTC come into force on 22 November 2025 and apply to insurance contracts concluded from 1 December 2025 onwards.

Before entering into the insurance contract, the Policyholder should carefully review the GTC and provide a copy of the GTC to each person wishing to join the insurance scheme.

Before joining the insurance, please read carefully the GTC provided to you by the Policyholder.

GLOSSARY

– what the terms used in these GTC mean

1. In these GTC, we use the following terms:
 - 1) **Cover Period** – the period during which we are liable to the Insured Person under the supplementary insurance;
 - 2) **Diagnostic and Therapeutic Procedure** – a medical process consisting of a medical history, physical examination of the patient and any additional diagnostic investigations required to establish a diagnosis, or any medical treatment provided for therapeutic purposes;
 - 3) **Supplementary Insurance** – the insurance contract to which these GTC apply;
 - 4) **Principal Insurance** – the PZU Na Życie Plus Group Insurance contract under which the Policyholder may take out the Supplementary Insurance.
2. Other terms used in these GTC are defined in the General Terms and Conditions of the Principal Insurance and shall have the same meaning when used in these GTC.

SUBJECT-MATTER INSURED

– what is insured

3. We insure your health.

SCOPE OF COVER AND BENEFIT AMOUNT

– the events for which we will pay a benefit and the amount payable

4. The scope of the supplementary insurance covers the occurrence, during the cover period, of an insured event affecting you that meets our definition set out in the Appendix to these GTC.
5. If you suffer an event specified in the Appendix to these GTC, we will pay you a benefit equal to the percentage of the Sum Insured applicable on the date the event occurs, as specified in the policy and in the individual certificate of insurance.

EXCLUSIONS OF COVER

– the circumstances in which no benefit will be payable

6. Our liability does not extend to any event specified in the Appendix to these GTC if the event occurred:
 - 1) as a result of acts of war;
 - 2) as a result of the Insured Person's active participation in acts of terrorism or civil unrest;
 - 3) as a result of the Insured Person committing or attempting to commit an act constituting an intentional criminal offence;
 - 4) as a result of a road traffic accident where the Insured Person was driving a vehicle:
 - a) without the driving licence or other authorisation required by law; or
 - b) after consuming alcohol or while under the influence of alcohol, within the meaning of the Act on Upbringing in Sobriety and Counteracting Alcoholism; or

- c) after using narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances within the meaning of the Act on Counteracting Drug Addiction, provided that any of these circumstances contributed to the occurrence of the road traffic accident;
- 5) where the Insured Person was under the influence of alcohol, within the meaning of the Act on Upbringing in Sobriety and Counteracting Alcoholism, or had used narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances within the meaning of the Act on Counteracting Drug Addiction, provided that any of these circumstances contributed to the occurrence of the insured event;
- 6) as a result of self-inflicted injury or an attempted suicide by the Insured Person;
- 7) directly as a result of poisoning caused by alcohol consumed or by the use of narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances, within the meaning of the Act on Counteracting Drug Addiction;
- 8) as a result of an accident that occurred before the beginning of the cover period.
- 7. Our liability also excludes any event specified in the Appendix to these GTC that occurred, or in respect of which a diagnostic and therapeutic procedure had commenced, during the three-year period preceding the commencement of the cover period. This exclusion does not apply to Clause 6.
- 8. The exclusion referred to in Clause 7 does not apply:
 - 1) where the diagnostic and therapeutic procedure commenced and was completed before the Insured Person reached the age of 18; or
 - 2) where there is no causal relationship between the previous occurrence and the current occurrence of the same event.
- 9. In the case of malignant cancer, only one benefit shall be payable, irrespective of the location, number or type of malignant tumours.
- 10. Once a benefit has been paid in respect of a particular event specified in the Appendix to these GTC, our cover in respect of that event shall cease.

WAITING PERIOD

– the period following your enrolment in the Supplementary Insurance during which our liability is excluded or limited

- 11. We shall not be liable during the first 90 days following your enrolment in the Supplementary Insurance.
- 12. We shall be liable if the insured event results from an accident that occurred during the first 90 days following your enrolment in the Supplementary Insurance, subject to the exclusions set out in Clause 6.

AMOUNT INSURED

– definition and amount

- 13. The Sum Insured is the amount used as the basis for calculating the benefit payable.
- 14. The amount of the Sum Insured is specified in the policy and in the individual certificate of insurance.
- 15. The Sum Insured remains unchanged throughout the term of the insurance contract. The Sum Insured may be changed by mutual agreement between the parties.

PREMIUM

– determination and payment of the premium

- 16. The premium for the Supplementary Insurance:
 - 1) reflects the waiting periods applicable under the Supplementary Insurance;
 - 2) is fixed, although it may be changed by mutual agreement between the parties;
 - 3) depends on:
 - a) the Sum Insured;
 - b) the scope of insurance;
 - c) the amount of the benefit;
 - d) the number of persons joining the insurance, their age and gender profile, and the nature of the work they perform.
- 17. The amount of the premium for the Supplementary Insurance is specified in the application for insurance and in the policy.
- 18. The Policyholder pays premiums for the Supplementary Insurance on a monthly basis together with the premium for the Principal Insurance.

TAKING OUT AND JOINING THE SUPPLEMENTARY INSURANCE

– how you become insured

- 19. The Supplementary Insurance may be taken out either at the same time as the Principal Insurance or during its term.
- 20. The Supplementary Insurance is available to Insured Persons who have joined the Principal Insurance. Before you join the supplementary insurance, we may ask you to complete a medical questionnaire.

DURATION OF THE SUPPLEMENTARY INSURANCE

– – the period for which the Supplementary Insurance is taken out

21. The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

RENEWAL OF THE SUPPLEMENTARY INSURANCE

– – the rules governing renewal of the Supplementary Insurance

22. Unless either party decides otherwise, and provided that the Principal Insurance remains in force, the Supplementary Insurance shall be automatically renewed for a further policy year on the same terms and conditions. In such circumstances, you, as the Insured Person, are not required to submit a new application to join the insurance.
23. Either party may elect not to renew the Supplementary Insurance by giving written notice to the other party. Such notice must be given no later than 30 days before the expiry of the Supplementary Insurance.

WITHDRAWAL FROM THE SUPPLEMENTARY INSURANCE

– – the circumstances in which the Policyholder may withdraw from the Supplementary Insurance

24. Withdrawal from the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
25. If the Policyholder withdraws from the Principal Insurance, this shall automatically result in withdrawal from the Supplementary Insurance.
26. If the Policyholder withdraws from the Supplementary Insurance, this shall not result in withdrawal from the Principal Insurance.

TERMINATION OF THE SUPPLEMENTARY INSURANCE

– – how the Policyholder may terminate the Supplementary Insurance

27. Termination of the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
28. If the Policyholder terminates the Principal Insurance, this shall automatically result in termination of the Supplementary Insurance.
29. If the Policyholder terminates the Supplementary Insurance, this shall not result in termination of the Principal Insurance.

COMMENCEMENT OF COVER

– – when your insurance cover begins

30. Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy.
31. Cover under the Supplementary Insurance shall commence only if cover under the Principal Insurance is in force.

TERMINATION OF COVER

– – when the Supplementary Insurance ends

32. Insurance cover under the supplementary insurance shall terminate:
- 1) on the date cover under the Principal Insurance terminates;
 - 2) on the date we receive the Policyholder's notice of withdrawal from the Supplementary Insurance;
 - 3) on the expiry date of the Supplementary Insurance cover, where it is not renewed;
 - 4) on the last day of the month in which you opt out of the Supplementary Insurance;
 - 5) at the end of the month during which the Supplementary Insurance remains in force on its existing terms and conditions, where you have not provided the required consent to a change in the Supplementary Insurance;
 - 6) on the date the notice period for termination of the Supplementary Insurance expires;
 - 7) on the date the supplementary insurance contract is terminated.

PERSON ENTITLED TO THE BENEFIT

– – who is entitled to receive the benefit

33. You are entitled to receive the benefit.

PAYMENT OF THE BENEFIT

– – when we will pay the benefit

34. If you experience an insured event specified in the Appendix to these Terms and Conditions, please provide us with:
- 1) a completed benefit claim form;

- 2) medical documentation confirming the occurrence of the insured event;
 - 3) documentation confirming the circumstances of the accident, where the insured event resulted from an accident;
 - 4) the hospital discharge summary, where you have been hospitalised.
35. We may also:
- 1) request a medical opinion from a doctor appointed by us;
 - 2) require you to undergo medical examinations, where this is necessary to determine our liability.
36. We will bear the cost of any medical opinion or medical examinations that we request.
37. If the documents you provide are insufficient for us to determine your entitlement to the benefit, we may ask you to submit any additional documents required.
38. If any documents requested by us are in a language other than Polish, you must provide a Polish translation prepared by a sworn translator.
39. Our decision on payment of the benefit will be based on the documentation provided.

FINAL PROVISIONS

– – other important information

40. In matters not governed by the Supplementary Insurance, the General Terms and Conditions of the Principal Insurance, the provisions of the Polish Civil Code, the Insurance and Reinsurance Activity Act, and any other applicable laws and regulations shall apply.

APPENDIX
TO THE GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON

Insured events covered under this insurance and the date on which an insured event is deemed to have occurred:

- 1) **Benign brain tumour** – a benign intracranial tumour of the brain, meninges or intracranial portions of the cranial nerves.
We shall provide cover only where the benign brain tumour has been diagnosed on the basis of brain imaging or histopathological examination and has been removed or, where removal of the tumour was not possible, neurological deficits have been confirmed. Our cover does not extend to cysts, granulomas, vascular malformations, cerebral haematomas or pituitary tumours. The date of occurrence of the insured event shall be the date on which, according to the medical records, the following conditions were met:
 - a) brain imaging was performed or a specimen was obtained for the examinations referred to above, confirming the benign brain tumour; and
 - b) the treatment referred to above was carried out or the neurological deficits referred to above were confirmed.
- 2) **Benign spinal cord tumour** – a benign intradural tumour of the spinal cord or spinal meninges. We shall provide cover only where the benign spinal cord tumour has been diagnosed on the basis of imaging or histopathological examination and has been removed or, where removal of the tumour was not possible, neurological deficits have been confirmed.
Our cover does not extend to cysts, granulomas, vascular malformations or spinal cord haematomas.
The date of occurrence of the insured event shall be the date on which, according to the medical records, the following conditions were met:
 - a) imaging was performed or a specimen was obtained for the examinations referred to above, confirming the benign spinal cord tumour; and
 - b) the treatment referred to above was carried out or the neurological deficits referred to above were confirmed.
- 3) **Malignant tumour** – uncontrolled proliferation of malignant cells capable of invading and destroying surrounding tissues and forming distant metastases, diagnosed on the basis of histopathological examination. We shall also provide cover for metastatic malignant cancer where no specimen has been obtained for histopathological examination, provided that the clinical presentation and diagnostic investigations clearly confirm the malignant nature of the neoplastic process.
Our cover does not extend to:
 - a) cutaneous melanoma staged as T1aN0M0 according to the TNM classification, or any skin cancer, including cutaneous lymphoma;
 - b) papillary thyroid carcinoma staged as T1aN0M0 according to the TNM classification;
 - c) prostate cancer with a Gleason score of 6 or classified as ISUP Grade Group 1;
 - d) cervical cancer and cervical dysplasia classified as CIN1, CIN2 or CIN3;
 - e) Hodgkin lymphoma classified as Stage I;
 - f) malignant cancers classified as pre-invasive (carcinoma in situ);
 - g) malignant cancers associated with AIDS or HIV infection;
 - h) tumours of borderline malignancy, tumours of low malignant potential, non-invasive tumours, dysplasia and benign tumours.

The date of occurrence of the insured event shall be the date on which, according to the medical records, the specimen for histopathological examination was obtained.



**INSURANCE PRODUCT INFORMATION DOCUMENT
AND GENERAL TERMS AND CONDITIONS OF THE
SUPPLEMENTARY GROUP INSURANCE AGAINST
SERIOUS ONCOLOGICAL DISEASES OF THE INSURED
PERSON – MEDICAL SERVICES**



SUPPLEMENTARY GROUP INSURANCE SUPPLEMENTARY GROUP INSURANCE AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON – MEDICAL SERVICES

Terms and Conditions Code: CMGP56

Document version dated 22 November 2025

This document contains information about the insurance product. Full details of the insurance are set out in the other insurance documents, in particular in the General Terms and Conditions of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person – Medical Services, Terms and Conditions Code: CMGP56 (the GTC). Before deciding whether to enter into the insurance contract, please read the GTC carefully. Definitions used in the GTC may differ from their commonly accepted meaning; therefore, please pay particular attention to them. The conclusion of the contract is voluntary.

THIS DOCUMENT:

- is provided for information purposes only;
- does not form part of the insurance contract (the Contract);
- does not constitute an offer within the meaning of Article 66 of the Polish Civil Code;
- should not be relied upon as the sole basis for making a decision to enter into the Contract.

SUBJECT MATTER AND SCOPE OF COVER

We insure the health of the Insured Person.

The supplementary insurance covers the occurrence, during the cover period, of an insured event for which we have paid a benefit under the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.

PRODUCT FEATURES – THE MAIN FEATURES OF OUR INSURANCE

If an insured event occurs for which we have paid a benefit under the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person, you will be entitled to use the medical services listed in the Appendix to these GTC. You may use the medical services until the applicable limit has been exhausted (as specified in the Appendix to these GTC), but for no longer than 24 months from the date of the decision confirming your entitlement to use the medical services.

The supplementary insurance may be taken out either at the same time as the principal insurance policy – PZU Na Życie Plus (PZU Na Życie Plus Group Insurance) or during its term, provided that the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person is taken out at the same time or is already in force.

ELIGIBILITY TO ENTER INTO THE CONTRACT AND PERSONS COVERED

The Supplementary Insurance is taken out by the Policyholder, who is responsible for paying the insurance premium. The Supplementary Insurance is available to Insured Persons who have joined both the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.

DURATION OF THE CONTRACT

The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

TERRITORIAL SCOPE OF COVER

Insurance cover applies worldwide.

PAYMENT OF PREMIUMS

Premiums are paid by the Policyholder on a monthly basis together with the premium for the principal insurance policy.

COMMENCEMENT AND TERMINATION OF INSURANCE COVER

Cover under the Supplementary Insurance commences in accordance with the rules set out in the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.

Cover under the Supplementary Insurance shall commence only if cover under the Principal Insurance is in force.

Insurance cover under the supplementary insurance shall terminate:

- on the date cover under the Principal Insurance or the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person ends;
- on the date we receive the Policyholder's notice of withdrawal from the supplementary insurance;
- on the expiry date of the supplementary insurance cover, where it is not renewed;
- on the last day of the month in which you opt out of the supplementary insurance;
- at the end of the month during which the supplementary insurance remains in force on its existing terms and conditions, if you have not provided the required consent to a change in the supplementary insurance;
- on the date the notice period for termination of the supplementary insurance expires;
- on the date the supplementary insurance contract is terminated.

MAIN EXCLUSIONS AND LIMITATIONS OF INSURANCE COVER

No benefit will be payable in the following circumstances:

- if the same insured event occurs again after a benefit has already been paid in respect of a previous occurrence of that event;
- if the documents required to assess the validity of the claim are not provided, unless we are able to determine our liability or the amount of the benefit on the basis of other available evidence;
- if the insured event occurs before the commencement of our cover period.

In addition, we shall not be liable where the event concerned falls outside the scope of cover, does not meet the definition specified in the Contract, where our liability has ceased, or in any other circumstances specified in the GTC.

TERMINATION OF THE CONTRACT

The Policyholder may withdraw from the supplementary insurance contract within:

- 7 days of entering into the contract, if the Policyholder is a business undertaking;
- 30 days of entering into the contract, if the Policyholder is not a business undertaking.

After this period, the Policyholder may terminate the contract by giving written notice.

The Policyholder may elect not to renew the supplementary insurance by submitting a written declaration of non-renewal no later than 30 days before the expiry of the insurance period.

INSURANCE DISTRIBUTOR'S REMUNERATION

Under the proposed contract, the insurance distributor receives commission-based remuneration.

COMPLAINTS, GRIEVANCES AND APPEALS

1. A complaint, grievance or appeal may be submitted at any of our customer service offices.
2. A complaint, grievance or appeal may be made:
 - 1) in writing – in person or by post within the meaning of the Postal Law Act, for example by writing to: PZU Życie SA ul. Postępu 18A, 02-676 Warsaw (correspondence address only), or by submitting correspondence through a postal or delivery service provider operating within the European Union;
 - 2) in writing – by sending it to the electronic delivery address of PZU Życie SA within the meaning of the Electronic Deliveries Act: AE:PL-50066-37983-FBWRA-37, as registered in the electronic address database referred to in the Act on Electronic Delivery;
 - 3) verbally – by telephone, for example by calling our helpline on 801 102 102, or in person at one of our offices, in which case the submission will be recorded in a written report;
 - 4) electronically – by sending an email to reklamacje@pzu.pl or by completing the online form available at pzu.pl or www.moje.pzu.pl.

3. We will respond to any complaint or grievance as soon as possible and no later than 30 days from the date of receipt. In particularly complex cases, where it is not possible to provide a response within 30 days, we will inform you:
 - 1) of the reasons for the delay;
 - 2) of the circumstances that still need to be established in order to resolve the matter;
 - 3) of the revised deadline for our response, which shall not exceed 60 days from the date on which we received the complaint, grievance or appeal.
4. Responses to complaints, grievances or appeals will be provided to the person who submitted them:
 - 1) where the customer is a natural person, in writing; however, the response may be provided by electronic mail solely at the customer's request;
 - 2) where the customer is an entity other than that referred to in item 1, in writing or by means of another durable medium.
5. If, following the investigation of the complaint:
 - 1) we have not upheld the claims submitted; or
 - 2) we have upheld the claims but have failed to carry out, within the timeframe specified in our response, the actions we undertook to perform,
 - the individual who submitted the complaint may refer the matter to the Financial Ombudsman by submitting an application.
6. Complaints, grievances and appeals are considered by the organisational units responsible for the subject matter of the case.
7. Further information regarding complaints can be found in the Act on the Handling of Complaints by Financial Market Entities, the Financial Ombudsman and the Financial Education Fund, as well as in the Insurance Distribution Act.
8. We provide for the possibility of resolving disputes through out-of-court dispute resolution procedures.
9. For the purposes of the Act on Out-of-Court Consumer Dispute Resolution, the entity authorised to conduct out-of-court dispute resolution proceedings in relation to PZU Życie SA is the Financial Ombudsman. Financial Ombudsman's website: rf.gov.pl.
10. Where the Insured Person, the Policyholder, the Beneficiary or any entitled person is a consumer, they may also seek assistance from their municipal or district Consumer Ombudsman.
11. The language used by us in our dealings with consumers is Polish.
12. PZU Życie SA is supervised by the Polish Financial Supervision Authority (KNF).

The table below identifies the provisions of the General Terms and Conditions of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person – Medical Services, Terms and Conditions Code CMGP56 (the GTC), which set out the principal terms of the insurance contract.

This information forms part of the GTC and is provided pursuant to statutory requirements (Article 17(1) of the Insurance and Reinsurance Activity Act).

No.	Type of information	Clause reference
1.	Conditions for benefit payment	Clauses 1–2 Clauses 4–6 Clause 28 Clauses 29–31 Clause 32
2.	Limitations and exclusions of the insurer's liability entitling it to refuse payment of benefits or to reduce the amount payable	Clauses 1–2 Clause 6 Clauses 25–26 Clause 27 Clause 32





GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON – MEDICAL SERVICES

GTC Code: CMGP56

The Management Board of PZU Życie SA adopted these General Terms and Conditions of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person – Medical Services by Resolution No. UZ/165/2025 dated 14 October 2025 (hereinafter referred to as the GTC).

These GTC come into force on 22 November 2025 and apply to insurance contracts concluded from 1 December 2025 onwards.

Before entering into the insurance contract, the Policyholder should carefully review the GTC and provide a copy of the GTC to each person wishing to join the insurance scheme.

Before joining the insurance, please read carefully the GTC provided to you by the Policyholder.

GLOSSARY

– what the terms used in these GTC mean

1. In these GTC, we use the following terms:
 - 1) **Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person** – the supplementary insurance specified by PZU Życie SA in the insurance contract, providing cover against serious oncological diseases of the insured person;
 - 2) **Medical facility** – an outpatient clinic, doctor's surgery or laboratory providing medical services, a list of which is published on pzu.pl and is also available via the Medical Helpline (the number is provided in the decision confirming entitlement to medical services) and at each of our branches;
 - 3) **Cover Period** – the period during which we are liable to the Insured Person under the supplementary insurance;
 - 4) **Supplementary Insurance** – the insurance contract to which these GTC apply;
 - 5) **Principal Insurance** – the PZU Na Życie Plus Group Insurance contract under which the Policyholder may take out the Supplementary Insurance;
 - 6) **Medical services** – the services listed in the Appendix to these GTC.
2. Other terms used in these GTC are defined in the General Terms and Conditions of the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person and have the same meanings in these GTC.

SUBJECT-MATTER INSURED

– what is insured

3. We insure your health.

SCOPE OF INSURANCE AND BENEFITS UNDER THE CONTRACT

– the insured events for which you are entitled to medical services and how you may use them

4. The supplementary insurance covers the occurrence, during the cover period, of an insured event for which we have paid a benefit under the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.
5. If an insured event occurs for which we have paid a benefit under the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person, you will be entitled to use the medical services listed in the Appendix to these GTC.
6. You may use the medical services until the applicable limit has been exhausted (as specified in the Appendix to these GTC), but for no longer than 24 months from the date of the decision confirming your entitlement to use the medical services.

PREMIUM

– determination and payment of the premium

7. The premium for the Supplementary Insurance:
 - 1) is fixed, although it may be changed by mutual agreement between the parties;
 - 2) depends on the scope of insurance, the number, age and gender distribution of the persons joining the insurance, as well as the type of work they perform.

8. The amount of the premium for the Supplementary Insurance is specified in the application for insurance and in the policy.
9. The Policyholder pays premiums for the Supplementary Insurance on a monthly basis together with the premium for the Principal Insurance.

TAKING OUT AND JOINING THE SUPPLEMENTARY INSURANCE

– how you become insured

10. The Supplementary Insurance may be taken out either at the same time as the Principal Insurance or during its term, provided that the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person is entered into simultaneously or is already in force with the Policyholder.
11. The Supplementary Insurance is available to Insured Persons who have joined the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person. Before you join the supplementary insurance, we may ask you to complete a medical questionnaire.

DURATION OF THE SUPPLEMENTARY INSURANCE

– the period for which the Supplementary Insurance is taken out

12. The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

RENEWAL OF THE SUPPLEMENTARY INSURANCE

– the rules governing renewal of the Supplementary Insurance

13. Unless either party decides otherwise and provided that both the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person remain in force, the Supplementary Insurance shall be automatically renewed for the next policy year on the same terms. In such circumstances, you, as the Insured Person, are not required to submit a new application to join the insurance.
14. Either party may elect not to renew the Supplementary Insurance by giving written notice to the other party. Such notice must be given no later than 30 days before the expiry of the Supplementary Insurance.

WITHDRAWAL FROM THE SUPPLEMENTARY INSURANCE

– the circumstances in which the Policyholder may withdraw from the Supplementary Insurance

15. Withdrawal from the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
16. If the Policyholder withdraws from the Principal Insurance, this shall automatically result in withdrawal from the Supplementary Insurance.
17. If the Policyholder withdraws from the Supplementary Insurance, this shall not result in withdrawal from the Principal Insurance.
18. If the Policyholder withdraws from the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person, this also constitutes withdrawal from the supplementary insurance.
19. If the Policyholder withdraws from the Supplementary Insurance, this does not constitute withdrawal from the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.

TERMINATION OF THE SUPPLEMENTARY INSURANCE

– how the Policyholder may terminate the Supplementary Insurance

20. Termination of the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
21. If the Policyholder terminates the Principal Insurance, this shall automatically result in termination of the Supplementary Insurance.
22. If the Policyholder terminates the Supplementary Insurance, this shall not result in termination of the Principal Insurance.
23. If the Policyholder terminates the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person, this also constitutes termination of the Supplementary Insurance.
24. If the policyholder terminates the Supplementary Insurance, this does not constitute termination of the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person.

COMMENCEMENT OF COVER

– when your insurance cover begins

25. Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy.
26. Cover under the supplementary insurance will commence only if cover under both the Principal Insurance and the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person is in force.

TERMINATION OF COVER

– when the Supplementary Insurance ends

27. Insurance cover under the supplementary insurance shall terminate:
- 1) on the date cover under the Principal Insurance or the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person ends;
 - 2) on the date we receive the Policyholder's notice of withdrawal from the Supplementary Insurance;
 - 3) on the expiry date of the Supplementary Insurance cover, where it is not renewed;
 - 4) on the last day of the month in which you opt out of the Supplementary Insurance;
 - 5) at the end of the month during which the Supplementary Insurance remains in force on its existing terms and conditions, where you have not provided the required consent to a change in the Supplementary Insurance;
 - 6) on the date the notice period for termination of the Supplementary Insurance expires;
 - 7) on the date the supplementary insurance contract is terminated.

PERSON ENTITLED TO THE BENEFIT

– who is entitled to the services

28. You are entitled to receive the medical services.

PAYMENT OF THE BENEFIT

– how to start using the medical services

29. We determine your entitlement to use the medical services on the basis of the documentation you provide. An application for payment of a benefit under the Supplementary Group Insurance Against Serious Oncological Diseases of the Insured Person also constitutes an application for entitlement to benefits under this Supplementary Insurance.
30. Once you receive our decision confirming your entitlement to use the medical services, you may begin using those services.
31. To use the medical services, you arrange an appointment for the relevant medical service through us. You may do so using the available channels specified in the Appendix to these GTC.

FINAL PROVISIONS

– other important information

32. In matters not governed by the Supplementary Insurance, the General Terms and Conditions of the Principal Insurance, the provisions of the Polish Civil Code, the Insurance and Reinsurance Activity Act, and any other applicable laws and regulations shall apply.

APPENDIX
TO THE GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP INSURANCE
AGAINST SERIOUS ONCOLOGICAL DISEASES OF THE INSURED PERSON – MEDICAL SERVICES

Scope of medical services

HOW TO ARRANGE A MEDICAL SERVICE

Medical services may be arranged through:



our 24-hour helpline on 801 405 905 or +48 22 505 15 48 (charges apply in accordance with the operator's tariff).

SMS SERVICE

Confirmation of the date, time and location of the medical service by SMS.

MEDICAL SERVICE	LIMIT
PRIMARY AND SPECIALIST CARE	
Outpatient consultations Outpatient consultations are provided without the need for a referral. They take place at a medical facility and, depending on the relevant medical speciality, may include: – physical examination of the patient, – taking a medical history, – providing a diagnosis, – recommending appropriate treatment, – issuing e-prescriptions, electronic sick notes (e-ZLA) and referrals (including e-referrals) related to further diagnostic and therapeutic procedures. We do not arrange or cover the costs of consultations provided by doctors holding senior academic titles (including the academic degrees of doctor, habilitated doctor or the title of professor).	
Outpatient consultations in the field of: 1. anaesthesiology, 2. vascular surgery, 3. general surgery, 4. oncological surgery, 5. internal medicine, 6. dermatology, 7. diabetology, 8. endocrinology, 9. physiotherapy, 10. gastroenterology, 11. gynaecology and obstetrics, 12. haematology, 13. cardiology, 14. neurology, 15. ophthalmology, 16. oncology, 17. trauma and orthopaedics, 18. otolaryngology, 19. psychiatry, 20. psychology, 21. pulmonology, 22. medical rehabilitation, 23. urology.	free of charge, 5 consultations – total limit for all consultations (including telemedicine consultations)

Telemedicine consultations

Telemedicine consultations are provided without the need for a referral. Consultations take place by telephone, via chat or video consultation and, depending on the relevant medical speciality, may include:

- taking a medical history,
- providing a diagnosis,
- recommending appropriate treatment,
- issuing e-prescriptions, electronic sick notes (e-ZLA) and referrals (including e-referrals) related to further diagnostic and therapeutic procedures.

Telemedicine consultations are available Monday to Friday from 7:00 a.m. to 10:00 p.m. Use of telemedicine consultations requires acceptance of the Telemedicine Provider's terms and conditions. We do not arrange or cover the costs of consultations provided by doctors holding senior academic titles (including the academic degrees of doctor, habilitated doctor or the title of professor).

Telemedicine consultations in the field of:

1. general surgery,
2. internal medicine,
3. dermatology,
4. diabetology,
5. endocrinology,
6. gastroenterology,
7. gynaecology and obstetrics,
8. cardiology,
9. neurology,
10. ophthalmology,
11. oncology,
12. trauma and orthopaedics,
13. otolaryngology,
14. psychology,
15. pulmonology,
16. urology

free of charge, 5 consultations – total limit for all consultations (including outpatient consultations)

LABORATORY DIAGNOSTICS

The procedures are performed at medical facilities designated by the service provider on the basis of a medical referral.

- alpha-fetoprotein (AFP),
- CA 125 antigen,
- CA 15-3 antigen,
- CA 19-9 antigen (gastrointestinal cancer antigen).
- carcinoembryonic antigen (CEA),
- beta-human chorionic gonadotropin (β -hCG) blood test,
- total prostate-specific antigen (tPSA).

free of charge, 8 procedures – total limit for all the procedures listed

DIAGNOSTIC IMAGING

The procedures are performed at medical facilities designated by the service provider on the basis of a medical referral.

Computed tomography (CT)

The insurance covers the cost of contrast medium.

The insurance does not cover CT angiography (CT angiogram), spiral CT, cone beam CT (CBCT), CT virtual colonoscopy, high-resolution CT (HRCT), Heidelberg Retina Tomography (HRT), optical coherence tomography (OCT), scanning laser OCT (SL-OCT) or cardiac CT.

- whole spine CT,
- head CT,
- abdominal CT,
- chest CT,
- pelvic bone CT,
- lumbar spine CT,
- thoracic spine CT,
- cervical spine CT,
- laryngeal CT,
- pelvic CT,
- wrist CT,
- orbital CT,
- temporal bone CT,
- lower leg CT,
- forearm CT
- pituitary gland CT,

free of charge, 1 procedure – total limit for all the procedures listed (CT and MRI)

• upper arm CT, • hand CT, • hip joint CT, • knee joint CT, • elbow joint CT, • shoulder joint CT, • ankle joint CT, • foot CT, • neck CT, • thigh CT, • paranasal sinus CT	free of charge, 1 procedure – total limit for all the procedures listed (CT and MRI)
Magnetic resonance imaging (MRI) The insurance covers the cost of contrast medium. The insurance does not cover MR angiography (MRA), MR enterography (MRE), or cardiac MRI.	
• whole spine MRI, • head MRI, • abdominal MRI, • chest MRI, • pelvic bone MRI, • lumbar spine MRI, • thoracic spine MRI, • cervical spine MRI, • pelvic MRI, • wrist MRI, • orbital MRI, • petrous temporal bone MRI, • lower leg MRI, • forearm MRI, • pituitary gland MRI, • upper arm MRI, • hand MRI, • hip joint MRI, • knee joint MRI, • elbow joint MRI, • shoulder joint MRI, • ankle joint MRI, • foot MRI, • thigh MRI, • paranasal sinus MRI,	free of charge, 1 procedure – total limit for all the procedures listed (CT and MRI)
SPECIALIST DIAGNOSTICS The procedures are performed at medical facilities designated by the service provider on the basis of a medical referral.	
Endoscopic examinations The insurance does not cover the cost of a CD recording of the examination.	
• gastroscopy without biopsy, • gastroscopy with biopsy for histopathological examination, • colonoscopy without biopsy, • colonoscopy with biopsy for histopathological examination, • rectoscopy without biopsy, • rectoscopy with biopsy for histopathological examination, • sigmoidoscopy without biopsy, • sigmoidoscopy with biopsy for histopathological examination,	free of charge, 2 procedures – total limit for all the procedures listed
OUTPATIENT REHABILITATION Rehabilitation procedures are performed at medical facilities designated by the service provider on the basis of a referral from a physician or physiotherapist.	
Physical therapy procedures	
• hot/cold hydrocollator therapy, • kinesiology taping (dynamic taping; excluding the cost of materials).	free of charge, 80 procedures – total limit for all outpatient rehabilitation procedures

Kinesiotherapy procedures

- active-assisted exercises with reduced weight-bearing,
- active free exercises,
- active resisted exercises,
- active-passive and assisted exercises,
- isometric exercises,
- general conditioning exercises,
- pneumatic massage,
- full dry massage,
- partial dry massage,
- neuromuscular re-education techniques,
- fascial therapy.

free of charge, 80 procedures
– total limit for all outpatient
rehabilitation procedures



**INSURANCE PRODUCT INFORMATION DOCUMENT
AND GENERAL TERMS AND CONDITIONS
OF THE SUPPLEMENTARY GROUP HOSPITAL
TREATMENT INSURANCE FOR THE INSURED PERSON**



SUPPLEMENTARY GROUP HOSPITAL TREATMENT INSURANCE FOR THE INSURED PERSON

Terms and Conditions Code: LSGP56

Document version dated 22 November 2025

This document contains information about the insurance product. Full details of the insurance are provided in other documents, in particular in the General Terms and Conditions of the Supplementary Group Hospital Treatment Insurance for the Insured Person, Terms and Conditions Code: LSGP56 (the GTC). Before deciding whether to enter into the insurance contract, please read the GTC carefully. Definitions used in the GTC may differ from their commonly accepted meaning; therefore, please pay particular attention to them.

The conclusion of the contract is voluntary.

THIS DOCUMENT:

- is provided for information purposes only;
- does not form part of the insurance contract (the Contract);
- does not constitute an offer within the meaning of Article 66 of the Polish Civil Code;
- should not be relied upon as the sole basis for making a decision to enter into the Contract.

SUBJECT MATTER AND SCOPE OF COVER

We insure the health of the Insured Person.

The scope of the Insurance covers the following insured events occurring during the period of insurance:

- hospital stay due to illness;
- hospital stay resulting from an accident.

PRODUCT FEATURES – THE MAIN FEATURES OF OUR INSURANCE

For each day of your hospital stay due to an illness or an accident (provided that the hospital stay lasted continuously for at least 4 days and was for the purpose of inpatient hospital treatment), we shall pay you a benefit equal to the percentage of the Sum Insured specified in the policy and in the individual certificate of insurance.

If your hospital stay commenced more than 12 months after the date of the accident, it shall be treated as a hospital stay due to an illness.

For each day of your first hospital stay for rehabilitation necessary to eliminate the direct consequences of an accident or an illness (provided that such hospital stay commenced no later than 12 months after the end of the Insured Person's hospital stay for which we paid a benefit and that it was related, as applicable, to the same accident or the same illness), we shall pay you a benefit at the same rate as for a hospital stay due to an illness.

The amount of the benefit shall be determined on the basis of the Sum Insured applicable on the date of the hospital stay.

If you stay in one or more hospitals without interruption, we shall treat it as a single hospital stay.

We shall pay the benefit for a maximum of 365 days of the Insured Person's hospital stay during each 12-month period between policy anniversaries.

The Supplementary Insurance may be taken out either at the same time as the Principal Insurance (PZU Na Życie Plus Group Insurance) or during its term.

ELIGIBILITY TO ENTER INTO THE CONTRACT AND PERSONS COVERED

The Supplementary Insurance is taken out by the Policyholder, who is responsible for paying the insurance premium.

The Supplementary Insurance is available to Insured Persons who have joined the Principal Insurance.

DURATION OF THE CONTRACT

The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

TERRITORIAL SCOPE OF COVER

Our insurance cover applies to hospital stays anywhere in the world.

PAYMENT OF PREMIUMS

Premiums are paid by the Policyholder on a monthly basis together with the premium for the principal insurance policy.

COMMENCEMENT AND TERMINATION OF INSURANCE COVER

Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy. Cover under the Supplementary Insurance shall commence only if cover under the Principal Insurance is in force.

Insurance cover under the supplementary insurance shall terminate:

- on the date cover under the Principal Insurance terminates;
- on the date we receive the Policyholder's notice of withdrawal from the supplementary insurance;
- on the expiry date of the supplementary insurance cover, where it is not renewed;
- on the last day of the month in which you opt out of the supplementary insurance;
- at the end of the month during which the supplementary insurance remains in force on its existing terms and conditions, if you have not provided the required consent to a change in the supplementary insurance;
- on the date the notice period for termination of the supplementary insurance expires;
- on the date the supplementary insurance contract is terminated.

MAIN EXCLUSIONS AND LIMITATIONS OF INSURANCE COVER

No benefit will be payable in the following circumstances:

- a hospital stay lasting fewer than 4 days;
- the absence of our insurance cover during the hospital stay;
- failure to provide the documents necessary to assess the validity of the claim.

In addition, we shall not be liable where the event concerned falls outside the scope of cover, does not meet the definition specified in the Contract, where our liability has ceased, or in any other circumstances specified in the GTC.

TERMINATION OF THE CONTRACT

The Policyholder may withdraw from the supplementary insurance contract within:

- 7 days of entering into the contract, if the Policyholder is a business undertaking;
- 30 days of entering into the contract, if the Policyholder is not a business undertaking.

After this period, the Policyholder may terminate the contract by giving written notice.

The Policyholder may elect not to renew the supplementary insurance by submitting a written declaration of non-renewal no later than 30 days before the expiry of the insurance period.

INSURANCE DISTRIBUTOR'S REMUNERATION

Under the proposed contract, the insurance distributor receives commission-based remuneration.

COMPLAINTS, GRIEVANCES AND APPEALS

1. A complaint, grievance or appeal may be submitted at any of our customer service offices.
2. A complaint, grievance or appeal may be made:
 - 1) in writing – in person or by post within the meaning of the Postal Law Act, for example by writing to: PZU Życie SA ul. Postępu 18A, 02-676 Warsaw (correspondence address only), or by submitting correspondence through a postal or delivery service provider operating within the European Union;
 - 2) in writing – by sending it to the electronic delivery address of PZU Życie SA within the meaning of the Electronic Deliveries Act: AE:PL-50066-37983-FBWRA-37, as registered in the electronic address database referred to in the Act on Electronic Delivery;
 - 3) verbally – by telephone, for example by calling our helpline on 801 102 102, or in person at one of our offices, in which case

- the submission will be recorded in a written report;
- 4) electronically – by sending an email to reklamacje@pzu.pl or by completing the online form available at pzu.pl or www.moje.pzu.pl.
3. We will respond to any complaint or grievance as soon as possible and no later than 30 days from the date of receipt. In particularly complex cases, where it is not possible to provide a response within 30 days, we will inform you:
- 1) of the reasons for the delay;
 - 2) of the circumstances that still need to be established in order to resolve the matter;
 - 3) of the revised deadline for our response, which shall not exceed 60 days from the date on which we received the complaint, grievance or appeal.
4. Responses to complaints, grievances or appeals will be provided to the person who submitted them:
- 1) where the customer is a natural person, in writing; however, the response may be provided by electronic mail solely at the customer's request;
 - 2) where the customer is an entity other than that referred to in item 1, in writing or by means of another durable medium.
5. If, following the investigation of the complaint:
- 1) we have not upheld the claims submitted; or
 - 2) we have upheld the claims but have failed to carry out, within the timeframe specified in our response, the actions we undertook to perform,
 - the individual who submitted the complaint may refer the matter to the Financial Ombudsman by submitting an application.
6. Complaints, grievances and appeals are considered by the organisational units responsible for the subject matter of the case.
7. Further information regarding complaints can be found in the Act on the Handling of Complaints by Financial Market Entities, the Financial Ombudsman and the Financial Education Fund, as well as in the Insurance Distribution Act.
8. We provide for the possibility of resolving disputes through out-of-court dispute resolution procedures.
9. For the purposes of the Act on Out-of-Court Consumer Dispute Resolution, the entity authorised to conduct out-of-court dispute resolution proceedings in relation to PZU Życie SA is the Financial Ombudsman. Financial Ombudsman's website: rf.gov.pl.
10. Where the Insured Person, the Policyholder, the Beneficiary or any entitled person is a consumer, they may also seek assistance from their municipal or district Consumer Ombudsman.
11. The language used by us in our dealings with consumers is Polish.
12. PZU Życie SA is supervised by the Polish Financial Supervision Authority (KNF).

The table below sets out the provisions of the General Terms and Conditions of the Supplementary Group Hospital Treatment Insurance for the Insured Person, Terms and Conditions Code LSGP56 (the GTC), which specify the principal terms and conditions of the insurance contract. This information forms part of the GTC and is provided pursuant to statutory requirements (Article 17(1) of the Insurance and Reinsurance Activity Act).

No.	Type of information	Clause reference
1.	Conditions for benefit payment	Clauses 1–2 Clauses 4–11 Clauses 17–19 Clause 37 Clauses 38–41 Clause 42
2.	Limitations and exclusions of the insurer's liability entitling it to refuse payment of benefits or to reduce the amount payable	Clauses 1–2 Clauses 12–14 Clauses 15–16 Clauses 34–35 Clause 36 Clause 42



GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP HOSPITAL TREATMENT INSURANCE FOR THE INSURED PERSON



GTC Code: LSGP56

The Management Board of PZU Życie SA adopted these General Terms and Conditions of the Supplementary Group Hospital Treatment Insurance for the Insured Person by Resolution No. UZ/165/2025 dated 14 October 2025 (hereinafter referred to as the GTC).

These GTC come into force on 22 November 2025 and apply to insurance contracts concluded from 1 December 2025 onwards.

Before entering into the insurance contract, the Policyholder should carefully review the GTC and provide a copy of the GTC to each person wishing to join the insurance scheme.

Before joining the insurance, please read carefully the GTC provided to you by the Policyholder.

GLOSSARY

– what the terms used in these GTC mean

1. In these GTC, we use the following terms:
 - 1) **Illness** – a condition of the body consisting in an abnormal response of its systems or organs to external or internal stimuli;
 - 2) **Hospital treatment** – inpatient treatment provided in a hospital for:
 - a) emergency conditions where delay in medical assistance may result in loss of health or life; or
 - b) conditions for which the therapeutic objective cannot be achieved through outpatient treatment;
 - 3) **Cover Period** – the period during which we are liable to the Insured Person under the supplementary insurance;
 - 4) **Hospital stay** – a stay in hospital lasting continuously for at least 4 days for the purpose of inpatient hospital treatment. The first day of the hospital stay shall be the date of admission, and the last day shall be the date of discharge from hospital;
 - 5) **Leave of absence during a hospital stay** – a temporary, documented absence of the Insured Person from hospital, authorised by the attending physician and confirmed by an appropriate entry in the medical records;
 - 6) **Hospital** – an inpatient healthcare facility providing round-the-clock healthcare services consisting of diagnosis, treatment, nursing care and rehabilitation that cannot be provided on an outpatient basis;
 - 7) **Supplementary Insurance** – the insurance contract to which these GTC apply;
 - 8) **Principal Insurance** – the PZU Na Życie Plus Group Insurance contract under which the Policyholder may take out the Supplementary Insurance.
2. Other terms used in these GTC are defined in the General Terms and Conditions of the Principal Insurance and shall have the same meaning when used in these GTC.

SUBJECT-MATTER INSURED

– what is insured

3. We insure your health.

SCOPE OF COVER AND BENEFIT AMOUNT

– the events for which we will pay a benefit and the amount payable

4. The scope of the Supplementary Insurance covers the following insured events occurring during the period of insurance:
 - 1) hospital stay due to illness;
 - 2) hospital stay resulting from an accident.
5. Our insurance cover applies to hospital stays anywhere in the world.
6. For each day of your hospital stay due to an illness or an accident, we shall pay you a benefit equal to the percentage of the Sum Insured specified in the policy and in the individual certificate of insurance, subject to the following clause.
7. If your hospital stay commenced more than 12 months after the date of the accident, it shall be treated as a hospital stay due to an illness.

8. For each day of your first hospital stay for rehabilitation necessary to eliminate the direct consequences of an accident or an illness referred to in Clause 12(14), we shall pay you a benefit at the same rate as for a hospital stay due to an illness.
9. We shall pay the benefit for a maximum of 365 days of the hospital stay during each 12-month period between policy anniversaries.
10. The amount of the benefit shall be determined on the basis of the Sum Insured applicable on the date of the hospital stay.
11. If you stay in one or more hospitals without interruption, we shall treat it as a single hospital stay. The continuity requirement shall be deemed satisfied where you are admitted to two or more hospital wards on consecutive days, regardless of the time of discharge from one ward or admission to another.

EXCLUSIONS OF COVER

– the circumstances in which no benefit will be payable

12. Our liability does not cover a hospital stay that commenced before the beginning of the cover period or a hospital stay resulting from:
 - 1) as a result of acts of war;
 - 2) disasters causing radioactive, chemical or biological contamination;
 - 3) as a result of the Insured Person's active participation in acts of terrorism or civil unrest;
 - 4) the Insured Person's attempted commission or commission of an act constituting an intentional criminal offence under applicable law;
 - 5) a traffic accident, where the Insured Person was driving a vehicle:
 - a) without the driving licence or other authorisation required by law; or
 - b) after consuming alcohol or while under the influence of alcohol, within the meaning of the Act on Upbringing in Sobriety and Counteracting Alcoholism; or
 - c) after using narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances within the meaning of the Act on Counteracting Drug Addiction, provided that any of these circumstances contributed to the occurrence of the road traffic accident;
 - 6) where the Insured Person was under the influence of alcohol, within the meaning of the Act on Upbringing in Sobriety and Counteracting Alcoholism, or had used narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances, within the meaning of the Act on Counteracting Drug Addiction, provided that any of these circumstances contributed to the occurrence of the insured event referred to in Clause 4;
 - 7) as a result of the Insured Person's self-inflicted injury or attempted suicide;
 - 8) directly as a result of poisoning caused by alcohol consumed or by the use of narcotic drugs, intoxicating substances, psychotropic substances, substitute substances or new psychoactive substances, within the meaning of the Act on Counteracting Drug Addiction, or as a result of conditions caused by the abuse of the aforementioned substances;
 - 9) the Insured Person's use of medicinal products contrary to a physician's instructions or contrary to the information contained in the package leaflet accompanying the medicinal product, or illnesses resulting from the abuse of such medicinal products;
 - 10) in connection with the treatment of mental disorders or behavioural disorders classified under categories F00–F99 of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) or categories 6A00–6E8Z of the International Classification of Diseases (ICD-11), as specified in Appendix No. 3 to these GTC;
 - 11) infertility treatment;
 - 12) cosmetic or aesthetic surgery, except where such surgery is necessary to remove the consequences of:
 - a) an accident occurring during the period of insurance; or
 - b) a malignant neoplasm occurring during the period of insurance;
 - 13) in connection with gender reassignment surgery;
 - 14) in connection with rehabilitation, except for the Insured Person's first hospital stay for rehabilitation necessary to eliminate the direct consequences of an accident or an illness, provided that such hospital stay commenced no later than 12 months after the end of the Insured Person's hospital stay for which we paid a benefit and that it was related, as applicable, to the same accident or the same illness;
 - 15) as a result of an accident, where the Insured Person was participating in any of the following sports: motor sports, powerboat sports, air sports, rock climbing or mountaineering (defined as any climbing above 2,000 metres above sea level), caving, scuba diving using specialised breathing equipment (excluding snorkelling), diving, or bungee jumping, provided that any of these circumstances contributed to the occurrence of the accident.
13. We shall not be liable for any stay:
 - 1) in hospices, addiction treatment facilities, chronic care facilities or nursing care facilities;
 - 2) in health resort treatment facilities, including sanatoria and health resort hospitals;
 - 3) in rehabilitation centres, rehabilitation hospitals or rehabilitation wards, except for the stay referred to in item 12(14);
 - 4) in day-care wards;
 - 5) in healthcare facilities that are not intended to provide inpatient hospital treatment.
14. No benefit is payable for full days during which the Insured Person was on authorised leave during the hospital stay. The benefit is payable for the day on which the child commenced authorised leave and the day on which the child returned from such leave.

WAITING PERIOD

– the period following your enrolment in the Supplementary Insurance during which our liability is excluded or limited

15. We shall not be liable during the first 30 days following your enrolment in the Supplementary Insurance.
16. We shall be liable if the insured hospital stay results from an accident that occurred during the first 30 days following your enrolment in the Supplementary Insurance subject to the exclusions set out in Clauses 12-14.

AMOUNT INSURED

– definition and amount

17. The Sum Insured is the amount used as the basis for calculating the benefit payable.
18. The amount of the Sum Insured is specified in the policy and in the individual certificate of insurance.
19. The Sum Insured remains unchanged throughout the term of the insurance contract. The Sum Insured may be changed by mutual agreement between the parties.

PREMIUM

– determination and payment of the premium

20. The premium for the Supplementary Insurance:
 - 1) reflects the waiting periods applicable under the Supplementary Insurance;
 - 2) is fixed, although it may be changed by mutual agreement between the parties;
 - 3) depends on:
 - a) the Sum Insured;
 - b) the number of persons joining the insurance, their age and gender profile, and the nature of the work they perform.
21. The amount of the premium for the Supplementary Insurance is specified in the application for insurance and in the policy.
22. The Policyholder pays premiums for the Supplementary Insurance on a monthly basis together with the premium for the Principal Insurance.

TAKING OUT AND JOINING THE SUPPLEMENTARY INSURANCE

– how you become insured

23. The Supplementary Insurance may be taken out either at the same time as the Principal Insurance or during its term.
24. The Supplementary Insurance is available to Insured Persons who have joined the Principal Insurance.

DURATION OF THE SUPPLEMENTARY INSURANCE

– the period for which the Supplementary Insurance is taken out

25. The Policyholder may enter into the supplementary insurance contract for a fixed term. The duration of the supplementary insurance is confirmed in the policy. If the supplementary insurance is taken out between policy anniversaries, our insurance cover will remain in force until the next policy anniversary.

RENEWAL OF THE SUPPLEMENTARY INSURANCE

– the rules governing renewal of the Supplementary Insurance

26. Unless either party decides otherwise, and provided that the Principal Insurance remains in force, the Supplementary Insurance shall be automatically renewed for a further policy year on the same terms and conditions. In such circumstances, you, as the Insured Person, are not required to submit a new application to join the insurance.
27. Either party may elect not to renew the Supplementary Insurance by giving written notice to the other party. Such notice must be given no later than 30 days before the expiry of the Supplementary Insurance.

WITHDRAWAL FROM THE SUPPLEMENTARY INSURANCE

– the circumstances in which the Policyholder may withdraw from the Supplementary Insurance

28. Withdrawal from the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
29. If the Policyholder withdraws from the Principal Insurance, this shall automatically result in withdrawal from the Supplementary Insurance.
30. If the Policyholder withdraws from the Supplementary Insurance, this shall not result in withdrawal from the Principal Insurance.

TERMINATION OF THE SUPPLEMENTARY INSURANCE

– how the Policyholder may terminate the Supplementary Insurance

- 31. Termination of the Supplementary Insurance shall be governed by the rules set out in the Principal Insurance.
- 32. If the Policyholder terminates the Principal Insurance, this shall automatically result in termination of the Supplementary Insurance.
- 33. If the Policyholder terminates the Supplementary Insurance, this shall not result in termination of the Principal Insurance.

COMMENCEMENT OF COVER

– when your insurance cover begins

- 34. Cover under the supplementary insurance commences in accordance with the terms set out in the principal insurance policy.
- 35. Cover under the Supplementary Insurance shall commence only if cover under the Principal Insurance is in force.

TERMINATION OF COVER

– when the Supplementary Insurance ends

- 36. Insurance cover under the supplementary insurance shall terminate:
 - 1) on the date cover under the Principal Insurance terminates;
 - 2) on the date we receive the Policyholder's notice of withdrawal from the Supplementary Insurance;
 - 3) on the expiry date of the Supplementary Insurance cover, where it is not renewed;
 - 4) on the last day of the month in which you opt out of the Supplementary Insurance;
 - 5) at the end of the month during which the Supplementary Insurance remains in force on its existing terms and conditions, where you have not provided the required consent to a change in the Supplementary Insurance;
 - 6) on the date the notice period for termination of the Supplementary Insurance expires;
 - 7) on the date the supplementary insurance contract is terminated.

PERSON ENTITLED TO THE BENEFIT

– who is entitled to receive the benefit

- 37. You are entitled to receive the benefit.

PAYMENT OF THE BENEFIT

– when we will pay the benefit

- 38. In the event of your stay in a hospital, please provide us with:
 - 1) an application for payment of the benefit. You may submit the application:
 - a) after your hospital stay has ended;
 - b) during your hospital stay – the first application may be submitted after the first 30 days of the hospital stay, and each subsequent application after 60 days from the commencement of the hospital stay;
 - 2) the hospital discharge summary, if your hospital stay has ended;
 - 3) a document confirming the reason for the hospital stay, issued by the attending physician, if you submit a claim for payment of the benefit during your hospital stay.
- 39. If the documents you provide are insufficient for us to determine your entitlement to the benefit, we may ask you to submit any additional documents required.
- 40. If any documents requested by us are in a language other than Polish, you must provide a Polish translation prepared by a sworn translator.
- 41. Our decision on payment of the benefit will be based on the documentation provided.

FINAL PROVISIONS

– other important information

- 42. In matters not governed by the Supplementary Insurance, the General Terms and Conditions of the Principal Insurance, the provisions of the Polish Civil Code, the Insurance and Reinsurance Activity Act, and any other applicable laws and regulations shall apply.

APPENDIX

TO THE GENERAL TERMS AND CONDITIONS OF THE SUPPLEMENTARY GROUP HOSPITAL TREATMENT INSURANCE FOR THE INSURED PERSON

I. Mental and behavioural disorders classified in accordance with the International Statistical Classification of Diseases and Related Health Problems (ICD-10):	
F00	Dementia in Alzheimer's disease
F01	Vascular dementia
F02	Dementia in other diseases classified elsewhere
F03	Unspecified dementia
F04	Organic amnesic syndrome, not induced by alcohol or other psychoactive substances
F05	Delirium, not induced by alcohol or other psychoactive substances
F06	Other mental disorders due to brain damage and dysfunction and to physical disease
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction
F09	Unspecified organic or symptomatic mental disorder
F10	Mental and behavioural disorders due to use of alcohol
F11	Mental and behavioural disorders due to use of opioids
F12	Mental and behavioural disorders due to use of cannabinoids
F13	Mental and behavioural disorders due to use of sedatives or hypnotics
F14	Mental and behavioural disorders due to use of cocaine
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine
F16	Mental and behavioural disorders due to use of hallucinogens
F17	Mental and behavioural disorders due to use of tobacco
F18	Mental and behavioural disorders due to use of volatile solvents
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
F20	Schizophrenia
F21	Schizotypal disorder
F22	Persistent delusional disorders
F23	Acute and transient psychotic disorders
F24	Induced delusional disorder
F25	Schizoaffective disorders
F28	Other non-organic psychotic disorders
F29	Unspecified non-organic psychosis
F30	Manic episode
F31	Bipolar affective disorder
F32	Depressive episode
F33	Recurrent depressive disorder
F34	Persistent mood [affective] disorders
F38	Other mood [affective] disorders
F39	Unspecified mood [affective] disorder
F40	Phobic anxiety disorders
F41	Other anxiety disorders
F42	Obsessive-compulsive disorder
F43	Reaction to severe stress, and adjustment disorders
F44	Dissociative [conversion] disorders
F45	Somatoform disorders
F48	Other neurotic disorders

F50	Eating disorders
F51	Non-organic sleep disorders
F52	Sexual dysfunction, not caused by organic disorder or disease
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere
F55	Abuse of non-dependence-producing substances
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors
F60	Specific personality disorders
F61	Mixed and other personality disorders
F62	Enduring personality changes, not attributable to brain damage and disease
F63	Habit and impulse disorders
F64	Gender identity disorders
F65	Disorders of sexual preference
F66	Psychological and behavioural disorders associated with sexual development and orientation
F68	Other disorders of adult personality and behaviour
F69	Unspecified disorder of adult personality and behaviour
F70	Mild mental retardation
F71	Moderate mental retardation
F72	Severe mental retardation
F73	Profound mental retardation
F78	Other mental retardation
F79	Unspecified mental retardation
F80	Specific developmental disorders of speech and language
F81	Specific developmental disorders of scholastic skills
F82	Specific developmental disorder of motor function
F83	Mixed specific developmental disorders
F84	Pervasive developmental disorders
F88	Other disorders of psychological development
F90	Hyperkinetic disorders
F91	Conduct disorders
F92	Mixed disorders of conduct and emotions
F93	Emotional disorders with onset specific to childhood
F94	Disorders of social functioning with onset specific to childhood and adolescence
F95	Tic disorders
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

II. II. Mental, behavioural or neurodevelopmental disorders classified in accordance with the International Classification of Diseases for Mortality and Morbidity Statistics (ICD-11):

6A00	Disorders of intellectual development
6A01	Developmental speech or language disorders
6A02	Autism spectrum disorder
6A03	Developmental learning disorder
6A04	Developmental motor coordination disorder
6A05	Attention deficit hyperactivity disorder
6A06	Stereotyped movement disorder
6A0Y	Other specified neurodevelopmental disorders
6A0Z	Neurodevelopmental disorders, unspecified
6A20	Schizophrenia
6A21	Schizophrenia
6A22	Schizotypal disorder

6A23	Acute and transient psychotic disorder
6A24	Delusional disorder
6A25	Symptomatic manifestations of primary psychotic disorders
6A2Y	Other specified primary psychotic disorder
6A2Z	Schizophrenia or other primary psychotic disorders, unspecified
6A40	Catatonia associated with another mental disorder
6A41	Substance-induced or medication-induced catatonia
6A4Z	Catatonia, unspecified
6A60	Bipolar type I disorder
6A61	Bipolar type II disorder
6A62	Cyclothymic disorder
6A6Y	Other specified bipolar or related disorders
6A6Z	Bipolar or related disorders, unspecified
6A70	Single episode depressive disorder
6A71	Recurrent depressive disorder
6A72	Dysthymic disorder
6A73	Mixed depressive and anxiety disorder
6A7Y	Other specified depressive disorders
6A7Z	Depressive disorders, unspecified
6A80	Mood episode symptoms and manifestations in mood disorders
6A8Y	Other specified mood disorders
6A8Z	Mood disorders, unspecified
6B00	Generalized anxiety disorder
6B01	Panic disorder
6B02	Agoraphobia
6B03	Specific phobia
6B04	Social anxiety disorder
6B05	Separation anxiety disorder
6B06	Selective mutism
6B0Y	Other specified fear-related or anxiety disorders
6B0Z	Fear-related or anxiety disorders, unspecified
6B20	Obsessive-compulsive disorder
6B21	Body dysmorphic disorder
6B22	Olfactory reference disorder
6B23	Hypochondriasis
6B24	Hoarding disorder
6B25	Body-focused repetitive behaviour disorders
6B2Y	Other specified obsessive-compulsive or related disorders
6B2Z	Obsessive-compulsive or related disorders, unspecified
6B40	Post traumatic stress disorder
6B41	Complex post traumatic stress disorder
6B42	Prolonged grief disorder
6B43	Adjustment disorder
6B44	Reactive attachment disorder
6B45	Disinhibited social engagement disorder
6B4Y	Other specified disorders specifically associated with stress
6B4Z	Disorders specifically associated with stress, unspecified
6B60	Dissociative neurological symptom disorder
6B61	Dissociative amnesia
6B62	Trance disorder

6B63	Trance possession disorder
6B64	Dissociative identity disorder
6B65	Partial dissociative identity disorder
6B66	Depersonalization-derealization disorder
6B6Y	Other specified dissociative disorders
6B6Z	Dissociative disorders, unspecified
6B80	Anorexia nervosa
6B81	Bulimia nervosa
6B82	Binge eating disorder
6B83	Avoidant-restrictive food intake disorder
6B84	Pica
6B85	Rumination-regurgitation disorder
6B8Y	Other specified feeding or eating disorders
6B8Z	Feeding or eating disorders, unspecified
6C00	Enuresis
6C01	Encopresis
6C0Z	Elimination disorders, unspecified
6C20	Bodily distress disorder
6C21	Body integrity dysphoria
6C2Y	Other specified bodily distress or bodily experience disorders
6C2Z	Bodily distress or bodily experience disorders, unspecified
6C40	Disorders due to use of alcohol
6C41	Disorders due to use of cannabis
6C42	Disorders due to use of synthetic cannabinoids
6C43	Disorders due to use of opioids
6C44	Disorders due to use of sedatives, hypnotics or anxiolytics
6C45	Disorders due to use of cocaine
6C46	Disorders due to use of stimulants, including amphetamine, methamphetamine or methcathinone
6C47	Disorders due to use of synthetic cathinones
6C48	Disorders due to use of caffeine
6C49	Disorders due to use of hallucinogens
6C4A	Disorders due to use of nicotine
6C4B	Disorders due to use of volatile inhalants
6C4C	Disorders due to use of MDMA or related drugs, including MDA
6C4D	Disorders due to use of dissociative drugs, including ketamine and phencyclidine (PCP)
6C4E	Disorders due to use of other specified psychoactive substances, including medications
6C4F	Disorders due to use of multiple specified psychoactive substances, including medications
6C4G	Disorders due to use of unknown or unspecified psychoactive substances
6C4H	Disorders due to use of non-psychoactive substances
6C4Y	Other specified disorders due to substance use
6C4Z	Disorders due to substance use, unspecified
6C50	Gambling disorder
6C51	Gaming disorder
6C5Y	Other specified disorders due to addictive behaviours
6C5Z	Disorders due to addictive behaviours, unspecified
6C70	Pyromania
6C71	Kleptomania
6C72	Compulsive sexual behaviour disorder
6C73	Intermittent explosive disorder
6C7Y	Other specified impulse control disorders

6C7Z	Impulse control disorders, unspecified
6C90	Oppositional defiant disorder
6C91	Conduct-dissocial disorder
6C9Y	Other specified disruptive or dissocial behaviour disorders
6C9Z	Disruptive or dissocial behaviour disorders, unspecified
6D10	Personality disorder
6D11	Personality difficulty
6D30	Exhibitionistic disorder
6D31	Voyeuristic disorder
6D32	Paedophilic disorder
6D33	Coercive sexual sadism disorder
6D34	Frotteuristic disorder
6D35	Other paraphilic disorder involving non-consenting individuals
6D36	Paraphilic disorder involving solitary behaviour or consenting individuals
6D3Z	Paraphilic disorders, unspecified
6D50	Factitious disorder imposed on self
6D51	Factitious disorder imposed on another
6D5Z	Factitious disorders, unspecified
6D70	Delirium
6D71	Mild neurocognitive disorder
6D72	Amnesic disorder
6D80	Dementia due to Alzheimer's disease
6D81	Dementia due to cerebrovascular disease
6D82	Dementia due to Lewy body disease
6D83	Frontotemporal dementia
6D84	Dementia due to psychoactive substances, including medications
6D85	Dementia due to diseases classified elsewhere
6D86	Behavioural or psychological disturbances in dementia
6D8Y	Dementia due to other specified cause
6D8Z	Dementia due to unknown or unspecified cause
6E0Y	Other specified neurocognitive disorders
6E0Z	Neurocognitive disorders, unspecified
6E20	Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21	Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z	Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified
6E40	Psychological or behavioural factors affecting disorders or diseases classified elsewhere
6E60	Secondary neurodevelopmental syndrome
6E61	Secondary psychotic syndrome
6E62	Secondary mood syndrome
6E63	Secondary anxiety syndrome
6E64	Secondary obsessive-compulsive or related syndrome
6E65	Secondary dissociative syndrome
6E66	Secondary impulse control syndrome
6E67	Secondary neurocognitive syndrome
6E68	Secondary personality change
6E69	Secondary catatonia syndrome
6E6Y	Other specified secondary mental or behavioural syndrome
6E6Z	Secondary mental or behavioural syndrome, unspecified
6E8Y	Other specified mental, behavioural or neurodevelopmental disorders
6E8Z	Mental, behavioural or neurodevelopmental disorders, unspecified



ADDITIONAL GROUP INSURANCE IN THE EVENT OF SPECIALIST TREATMENT OF THE INSURED

Condition code: LCGP55

Version dated: 20.11.2021

This is the key information material. Full details of the insurance can be found in other documents, in particular the General Terms and Conditions of the group insurance in the case of specialised treatment of the insured, conditions code LCGP55 (GTC). Please read the GTCs before deciding to conclude the agreement. The definitions used in the GTCs can have meanings that deviate from their common meanings, so please make sure to pay particular attention to them.
The conclusion of the agreement is voluntary.

PRODUCT INFORMATION

- is presented for information purposes,
- is not part of the insurance agreement (agreement),
- does not constitute a trade offer within the meaning of article 66 of the Civil Code,
- should not be the sole basis for a decision on insurance.

THE SCOPE AND OBJECT OF INSURANCE – WHAT IS INSURED?

We insure the health of the insured.

Coverage includes specialist treatment that has commenced during the period of cover, i.e.:

- ablation,
- chemotherapy,
- dialysis therapy,
- radiotherapy for cancer,
- Gamma Knife or Cyber Knife cancer radiotherapy,
- interferon treatment,
- radioiodine therapy for non-cancerous thyroid diseases,
- cardioversion / defibrillator engraftment,
- implantation of cardiac resynchronization stimulator,
- implantation of heart stimulator (pacemaker).

PRODUCT CHARACTERISTICS – WHAT ARE THE MAIN FEATURES OF OUR INSURANCE?

We will pay a percentage of the sum insured current at the date of cover if the insured has a specialist treatment which commenced during our period of cover:

- administration of the first dose of a drug – in the case of chemotherapy or interferon therapy,
- administration of the first dose of ionising radiation – in the case of radiotherapy for cancer,
- performing the first radioiodine therapy for non-cancerous thyroid diseases,
- the first cardioversion / defibrillator engraftment,
- implantation of heart stimulator (pacemaker),
- implantation of cardiac resynchronization stimulator,
- performing the first Gamma Knife or Cyber Knife radiotherapy,
- performing the first ablation,
- performing the first dialysis treatment.

Supplementary insurance may be taken out either at the conclusion of the basic insurance – Group Insurance PZU Na Życie Plus or at its duration.

WHO CAN CONCLUDE AN AGREEMENT WITH US, WHO DO WE INSURE?

The additional insurance is concluded by the policyholder who pays the insurance premiums.
The additional insurance may be joined by insured persons who joined the basic insurance.

WHAT IS THE DURATION OF THE INSURANCE?

The policyholder may take out supplementary insurance with us for a limited period. We confirm the duration of the additional insurance in the policy. If the additional insurance is taken out between policy anniversaries, our cover continues until the next policy anniversary.

WHAT LOCATION DOES THE INSURANCE COVER?

The insurance cover operates worldwide, 24 hours a day.

HOW AND WHEN SHOULD THE CONTRIBUTIONS BE PAID?

The policyholder transfers the premium together with the premium for the basic insurance.

WHEN DOES THE INSURANCE COVERAGE BEGIN AND END?

Coverage under the supplementary insurance commences as described in the basic insurance. Cover under the additional insurance shall only commence if the cover under the basic insurance is in force. The cover under the supplementary insurance ceases:

- from the date of termination of cover under the primary insurance,
- from the date on which we receive the policyholder's declaration that he or she is withdrawing from the additional insurance,
- on the date of termination of cover under the supplementary insurance – if not renewed,
- on the last day of the month in which you cancel the supplementary insurance,
- at the end of the month of the supplementary insurance on the current terms and conditions, if they have not given the required consent to change the supplementary insurance,
- as from the date of expiry of the notice period of the supplementary insurance,
- as from the date on which the supplementary insurance is terminated.

MAIN EXCLUSIONS AND LIMITATIONS OF THE INSURANCE COVERAGE – WHAT IS NOT COVERED BY THE INSURANCE?

We will not pay the benefit in the event of:

- our lack of protection on the date of specialist treatment,
- the administration to the insured of each subsequent dose of medication in the case of chemotherapy and interferon therapy,
- the administration of each subsequent dose to the insured person in the case of radiotherapy for cancer.

In addition, we are not liable if a situation is not covered, it does not meet the definition set out in the agreement or our liability has ended (e.g. due to non-payment of premiums as well as in other cases indicated in the GTC).

HOW TO TERMINATE THE AGREEMENT?

The policyholder has the right to cancel the supplementary insurance agreement within 30 days after its conclusion or, if the policyholder is an entrepreneur, within 7 days from the conclusion of the agreement. After this period, the policyholder has the right to terminate the agreement by a written notice. The policyholder has right to cancel the extension of the additional insurance by sending us a written notice of non-renewal no later than 30 days prior to its termination.

REMUNERATION FOR THE DISTRIBUTOR OF THE INSURANCE

The distributor shall receive a commission in connection with the proposed agreement.

COMPLAINTS, OBJECTIONS AND GRIEVANCES

1. A claim, complaint or grievance shall be submitted to any of our units where we serve our customers.
2. A complaint, grievance or complaint can be submitted:
 - 1) in writing – in person or by mail, within the meaning of the Postal Law Act, for example by writing to the following address: PZU Życie SA 18A Postępu St., 02-676 Warsaw (address for correspondence only);
 - 2) in writing – sent to the address for electronic delivery of PZU Życie SA, within the meaning of the Electronic Delivery Act, from the date of entering that address into the database of electronic addresses;
 - 3) verbally – by phone, for instance by calling the telephone helpline on 801 102 102, or in person, confirmed by means of a protocol during a visit to our unit;
 - 4) electronically – by sending an e-mail to reklamacje@pzu.pl or by filling in the form at www.pzu.pl.

3. We respond to complaints, grievances and complaints as soon as possible, however no later than 30 days after the day on which we receive them. If we are unable to respond in particularly complex cases within 30 days, we will inform you:
 - 1) why the response is delayed;
 - 2) what circumstances we still need to establish in order to process the case;
 - 3) what is the new time limit for our response – it may not exceed 60 days from the date on which we received the complaint, claim or grievance.
4. We respond to complaints, claims and grievances to the person who made them:
 - 1) in cases where the customer is a natural person – in writing, except that the response may be delivered by e-mail only at the customer's request;
 - 2) where the customer is an entity other than those referred to in item 1 – in writing or using another durable medium.
5. If, after the complaint has been investigated:
 - 1) we have not honoured the claims made or
 - 2) we have accepted the claim, but within the time limit specified in the reply to that claim we have not conducted the acts we obliged to take– the individual who has made a complaint has the right to write to the Financial Ombudsman to request this.
6. We deal with complaints, grievances and complaints in our units, which have authority over the subject matter.
7. Additional information on complaints are provided in the Act on Complaints Handling by Financial Market Entities and Financial Ombudsman and in the Act on Insurance Distribution.
8. PZU provides for the possibility of resolving conflicts out of court.
9. The entity authorized within the meaning of the Act on out-of-court handling of consumer disputes, competent for PZU Życie SA to handle disputes out of court is the Financial Ombudsman. The website address: rf.gov.pl.
10. In the event that the insured or the policyholder, beneficiary and the rights holder are consumers, they can turn to the Municipal and District Consumer Ombudsmen for assistance.
11. PZU communicates with its consumers in Polish.
12. PZU is supervised by the Financial Supervision Authority.



**GENERAL TERMS
OF ADDITIONAL GROUP INSURANCE
IN THE EVENT OF A SPECIALIST TREATMENT OF
THE INSURED**

The table below presents the provisions of the general terms and conditions of the additional group insurance in the event of a bereavement of a child, terms and conditions code LCGP55 (GTC), which govern the exclusion and limitation of the insurance company's liability. These provisions constitute a part of the GTC, and their indications are a result of the legal regulations (Article 17, section 1 of the Insurance and Reinsurance Act).

No.	Type of information	Record number
1.	Conditions for benefit payment	items 1–2 items 4–5 items 12–14 item 32 items 33–36 item 37
2.	Restrictions and exemptions of an insurer's liability granting the right to refuse to pay out the benefits or to reduce them	items 1–2 items 6–9 items 10–11 items 29–30 item 31 item 37

Information about the insurance are available from:

 at pzu.pl



at the phone number 801 102 102
(charged according to the operator's tariff)

GENERAL TERMS AND CONDITIONS OF ADDITIONAL GROUP INSURANCE IN CASE OF SPECIALIST TREATMENT OF THE INSURED



GTC code: LCGP55

The Board of Directors of PZU Życie SA set out the general terms and conditions of the additional group insurance in case of specialist treatment of the insured by means of Resolution No. UZ/202/2021 of 9 November 2021 (hereinafter referred to as the GTC).

These General Terms and Conditions shall enter into force on 01 December 2021 and shall apply to insurance agreements concluded from 1 January 2022.

The policyholder shall read the GTC carefully before concluding the contract and communicate the GTC to anyone who wishes to take out insurance.

Please read the GTC you have received from your policyholder carefully before you take out insurance.

GLOSSARY

– i.e. what do the terms actually mean

1. The GTC uses the following terminology:

- 1) **ablation** – a procedure consisting in destroying or isolating an area in the heart that is the source of a heart rhythm disturbance. We are only responsible for such ablation of heart rhythm disturbances where a current generator or low temperature is used;
 - 2) **chemotherapy** – a method of treating a malignant tumour with at least one anti-cancer drug belonging to group L01 of the ATC classification. Our cover in this insurance does not include the use of group L02 hormonal drugs, group L03 immunostimulants or group L04 immunosuppressants of the ATC classification as a treatment for malignant tumour;
 - 3) **dialysis therapy** – a method of treating kidney failure by haemodialysis or peritoneal dialysis. We are only responsible for such dialysis therapy used to treat chronic renal failure. Our cover in this insurance does not include temporary dialysis therapy used in reversible renal failure;
 - 4) **insurance protection period** – the period of time during which our liability to the insured under the supplementary insurance continues;
 - 5) **radiotherapy for cancer** – a method of treatment using ionising radiation to treat malignant tumours or benign tumours;
 - 6) **gamma knife or cyber knife radiotherapy of cancer** – A method of treatment using stereotactic radiotherapy known as Gamma Knife or Cyber Knife for the treatment of malignant tumours or benign tumours;
 - 7) **interferon therapy** – a method of treatment using interferon. We are solely responsible for the interferon treatment of multiple sclerosis and chronic hepatitis C;
 - 8) **radioiodine therapy for non-cancerous thyroid diseases** – a method of treating non-cancerous thyroid diseases, through the use of a radioisotope of iodine, by irreversibly destroying thyroid tissue;
 - 9) **supplementary insurance** – the insurance agreement to which these GTC apply;
 - 10) **basic insurance** – PZU Na Życie Plus group insurance agreement, to which the policyholder has the right to take out additional insurance;
 - 11) **implantation of a cardioverter-defibrillator** – implantation of a permanent cardiac pacing device with defibrillation or cardioversion function into the patient's body. Our cover in this insurance does not include procedures for repositioning, revision and replacement of leads and pacing system;
 - 12) **implantation of a resynchronisation pacemaker** – a procedure to permanently implant a cardiac pacemaker with cardiac synchrony into the patient's body. Our cover in this insurance does not include procedures for repositioning, revision and replacement of leads and pacing system;
 - 13) **implantation of a cardiac pacemaker (implantation of a pacemaker)** – a procedure to permanently implant a cardiac pacing device, known as a pacemaker, into the patient's body, without the function of defibrillation, cardioversion and synchronisation of heart contraction. Our cover in this insurance does not include procedures for repositioning, revision and replacement of leads and pacing system.
2. The other terms used in these GTC are defined in the general terms and conditions of the basic insurance – the same terms retain the same meaning.

OBJECT OF INSURANCE

– what do we insure

3. We insure your health.

SCOPE OF INSURANCE AND THE BENEFIT AMOUNT

– which events do we pay for and what amounts

4. The supplementary insurance cover includes specialist treatment which has commenced during the period of cover i.e.:
 - 1) ablation;
 - 2) chemotherapy;
 - 3) dialysis therapy;
 - 4) radiotherapy for cancer;
 - 5) Gamma Knife or Cyber Knife cancer radiotherapy;
 - 6) interferon treatment;
 - 7) radioiodine therapy for non-cancerous thyroid diseases;
 - 8) cardioversion / defibrillator engraftment;
 - 9) implantation of cardiac resynchronization stimulator;
 - 10) implantation of heart stimulator (pacemaker).
5. In the event that you have a specialist treatment which has commenced during the period of cover, we will pay the percentage of the sum insured current at the date specified in the policy and in the individual confirmation of insurance:
 - 1) performing the first ablation;
 - 2) administration of the first dose of a drug – in the case of chemotherapy or interferon therapy;
 - 3) performing the first dialysis treatment;
 - 4) administration of the first dose of ionising radiation – in the case of radiotherapy for cancer;
 - 5) performing the first Gamma Knife or Cyber Knife radiotherapy of malignant degeneration;
 - 6) performing the first radioiodine therapy for non-cancerous thyroid diseases;
 - 7) the first cardioversion – defibrillator engraftment;
 - 8) implantation of cardiac resynchronization stimulator;
 - 9) implantation of heart stimulator (pacemaker).

PROTECTION RESTRICTIONS

– i.e. in which situations and how much the maximum insurance payout will be

6. Our liability covers the first use of the respective specialist treatment indicated in the GTC during the period of cover, subject to items 7 to 9.
7. If we pay the benefit after:
 - 1) ablation;
 - 2) chemotherapy or radiotherapy for cancer or Gamma Knife or Cyber Knife radiotherapy for cancer;
 - 3) dialysis therapy;
 - 4) interferon treatment;
 - 5) radioiodine therapy for non-cancerous thyroid diseases;
 - 6) cardioversion / defibrillator engraftment;
 - 7) implantation of cardiac resynchronization stimulator;
 - 8) implantation of heart stimulator (pacemaker)– then our cover for this specialist treatment, for which you have already received a benefit, ends.
8. If you have undergone the specialist treatment listed under item 4 prior to the start of our cover and the same treatment is given again during the period of cover, we will pay the benefit if there is no causal link between the current and previous treatment. We will not apply this exemption if your previous specialist treatment ended before you reached the age of 18.
9. If you have undergone radiotherapy for cancer, Gamma Knife or Cyber Knife radiotherapy for cancer or chemotherapy, we will only pay the benefit for one of these specialist treatments.

GRACE PERIOD

– the period of the lack of or limited liability of the insurance company after you have taken out supplementary insurance

10. We are not liable for the first 90 days counted from the moment you join the supplementary insurance.
11. We are liable if the specialist treatment was the result of an accident.

SUM INSURED

– what is it, and where is it indicated

12. The sum insured is the amount which we use as the basis for determining the benefit due.
13. The amount of the sum insured can be included in the policy and in the individual confirmation of insurance.
14. The sum insured does not change throughout the duration of the agreement. The sum insured is fixed, but may be changed by mutual agreement.

PREMIUM

– what does it depend on and when to pay it

15. Amount of the premium per the insured:
 - 1) takes into account the grace periods that apply in supplementary insurance;
 - 2) it is fixed, but may be changed by mutual agreement;
 - 3) it depends on:
 - a) the sum insured,
 - b) benefit amount,
 - c) the number, age structure and gender of those who take out insurance, as well as the type of work they do.
16. The amount of the premium applicable to the additional insurance agreement is specified in the application for conclusion of the agreement as well as in the policy.
17. The policyholder pays us the premiums for the supplementary insurance on a monthly basis, together with the premium for the primary insurance.

TAKING OUT AND JOINING SUPPLEMENTARY INSURANCE

– i.e., How do we insure you

18. Supplementary insurance may be taken out either with or during the conclusion of the basic insurance.
19. The additional insurance may be joined by insured persons who joined the basic insurance.

DURATION OF SUPPLEMENTARY INSURANCE

– i.e., which period we take out the supplementary insurance for

20. The policyholder may take out supplementary insurance with us for a limited period. We confirm the duration of the additional insurance in the policy. If the insurance is taken out between policy anniversaries, our cover continues until the next policy anniversary.

EXTENSION OF SUPPLEMENTARY INSURANCE

– what are the rules for extending supplementary insurance

21. Unless otherwise agreed by either party to the contract and provided that the primary insurance is in force, the supplementary insurance shall be automatically extended for the next policy year – under the same conditions. In this case, as an insured, you do not have to re-submit the declaration of membership.
22. Either party has the right to cancel the extension of the supplementary insurance, of which it shall notify the other party in writing. This must be done at the latest 30 days before the termination of this insurance.

WITHDRAWAL FROM SUPPLEMENTARY INSURANCE

– i.e. the conditions under which a policyholder may withdraw from the supplementary insurance

23. The cancellation of the additional insurance is carried out in accordance with the rules laid down in the basic insurance.
24. If the policyholder cancels the primary insurance, this results in cancellation of the secondary insurance.
25. If the policyholder withdraws from the additional insurance, this does not result in withdrawal from the primary insurance.

TERMINATION OF SUPPLEMENTARY INSURANCE

– i.e. the manner in which the policyholder can cancel the supplementary insurance

26. The termination of the supplementary insurance is carried out in accordance with the rules outlined in the basic insurance.
27. In the event the policyholder terminates the primary insurance, this results in the termination of the secondary insurance.
28. If the policyholder terminates the additional insurance, this does not result in termination of the primary insurance.

THE BEGINNING OF OUR PROTECTION

– when our insurance protection starts

29. Coverage under the supplementary insurance commences as described in the basic insurance.
30. Cover under the additional insurance shall only commence if the cover under the basic insurance is in force.

THE CESSATION OF OUR PROTECTION

– i.e. when the supplementary insurance ends

31. The cover under the supplementary insurance ceases:

- 1) from the date of termination of cover under the primary insurance;
- 2) from the date on which we receive the policyholder's declaration that he or she is withdrawing from the additional insurance;
- 3) on the date of termination of cover under the supplementary insurance – if not renewed;
- 4) on the last day of the month in which you cancel the supplementary insurance;
- 5) at the end of the month of the supplementary insurance on the current terms and conditions, if they have not given the required consent to change the supplementary insurance;
- 6) as from the date of expiry of the notice period of the supplementary insurance;
- 7) as from the date on which the supplementary insurance is terminated.

PERSONS ENTITLED TO OBTAIN THE BENEFIT

– the person to whom the payment is due

32. In such case you have the right to receive the benefit.

PROVISION OF THE HEALTH BENEFIT

– when we pay the benefit

33. After specialist treatment, please deliver to us:

- 1) a request for payment of a benefit;
- 2) medical records that confirm specialised treatment.

34. If the documents provided are not sufficient to consider that you are entitled to a benefit payment and in what amount, we may ask you for other necessary documents.

35. If the documents we have requested are in a language other than Polish, you must provide us with a Polish translation. This translation must be carried out by a sworn translator.

36. We decide on the payment of the benefit on the basis of the documentation provided.

FINAL PROVISIONS

– what other matters are important

37. Any matters not regulated by the supplementary insurance shall be subject to the general terms and conditions of basic insurance, the provisions of the Civil Code, the Act on Insurance and Reinsurance Activity and any other applicable laws.



ADDITIONAL GROUP INSURANCE FOREIGN MEDICAL CONSULTATION AND ASSISTANCE SERVICES

Condition code: KZGP55

Version dated: 20.11.2021

This is the key information material. Full details of the insurance can be found in other documents, in particular in the general conditions of the Additional Group Insurance Foreign Medical Consultations, conditions code: KZGP55 (GTC). Please read the GTCs before deciding to conclude the agreement. The definitions used in the GTCs can have meanings that deviate from their common meanings, so please make sure to pay particular attention to them. The conclusion of the agreement is voluntary.

PRODUCT INFORMATION

- is presented for information purposes,
- is not part of the insurance agreement (agreement),
- does not constitute a trade offer within the meaning of article 66 of the Civil Code,
- should not be the sole basis for a decision on insurance.

THE SCOPE AND OBJECT OF INSURANCE – WHAT IS INSURED?

We insure the health of:

- the insured person – in the basic scope or
- the insured and the co-insured – in the extended scope.

PRODUCT CHARACTERISTICS – WHAT ARE THE MAIN FEATURES OF OUR INSURANCE?

In the event of a medical occurrence, we enable the insured or co-insured to provide certain services during our period of cover. Supplementary insurance in both scopes covers the occurrence during the period of our coverage:

- medical events resulting in a benefit under:
 - foreign medical consultation
 - Assistance Services,
 - Assistance in Treatment Planning
 - 24-hour Medical Telephone Service or
- a health impairment resulting in a service under the 24-hour Medical Helpline.

Supplementary insurance may be taken out either at the conclusion of the basic insurance - Group Insurance PZU Na Życie Plus or at its duration.

WHO CAN CONCLUDE AN AGREEMENT WITH US, WHO DO WE INSURE?

The additional insurance may be joined by insured persons who joined the basic insurance. The policyholder may take out additional insurance:

- in one of two scopes, i.e. basic or extended, or
- in two scopes simultaneously, i.e. basic and extended.

WHAT IS THE DURATION OF THE INSURANCE?

The policyholder may take out supplementary insurance with us for a limited period. We confirm the duration of the additional insurance in the policy. If the additional insurance is taken out between policy anniversaries, our cover continues until the next policy anniversary.

WHAT LOCATION DOES THE INSURANCE COVER?

The insurance cover operates worldwide, 24 hours a day.

Assistance, Treatment Planning Assistance and 24/7 Medical Telephone Service are provided in Poland.

HOW AND WHEN SHOULD THE CONTRIBUTIONS BE PAID?

The premium is transferred by the policyholder together with the premium for the basic insurance.

WHEN DOES THE INSURANCE COVERAGE BEGIN AND END?

Coverage under the supplementary insurance commences as described in the basic insurance. Cover under the additional insurance shall only commence if the cover under the basic insurance is in force.

Co-insurance cover in respect of the insured shall end:

- from the date of termination of cover under the primary insurance;
- from the date on which we receive the policyholder's declaration that he or she is withdrawing from the additional insurance;
- on the date of termination of cover under the supplementary insurance – if not renewed;
- on the last day of the month in which you cancel the supplementary insurance;
- at the end of the month of the supplementary insurance on the current terms and conditions, if they have not given the required consent to change the supplementary insurance;
- as from the date of expiry of the notice period of the supplementary insurance;
- as from the date on which the supplementary insurance is terminated.

Co-insurance cover in respect of the co-insured shall end:

- from the date of termination of cover for the insured under the primary insurance,
- on the date of termination of cover for the insured in the supplementary insurance,
- on the policy anniversary date falling in the year in which the spouse or life partner turns 18,
- on the policy anniversary date falling in the year in which the spouse or life partner turns 70,
- the death of a co-insured person,
- on the last day of the month in which we received notification of the dissolution of the marriage to the primary insured,
- on the last day of the month in which we receive notification that the insured has changed from extended to basic coverage.

MAIN EXCLUSIONS AND LIMITATIONS OF THE INSURANCE COVERAGE – WHAT IS NOT COVERED BY THE INSURANCE?

We will not pay the benefit in following events:

- life-threatening incidents and consequences,
- where the insured or co-insured person was under the influence of alcohol within the meaning of the law on upbringing and counteracting alcoholism or after using: drugs, narcotics, psychotropic substances or substitutes within the meaning of the provisions on counteracting drug addiction – if that had an impact on the occurrence of the event covered by insurance,
- the benefits arranged by the Assistance Centre because the insured or co-insured person has provided an untrue statement – in such case, the costs of these services are borne by the insured or co-insured.

In addition, we are not liable if a situation is not covered, it does not meet the definition set out in the agreement or our liability has ended (e.g. due to non-payment of premiums as well as in other cases indicated in the GTC).

HOW TO TERMINATE THE AGREEMENT?

The policyholder has the right to cancel the supplementary insurance agreement within 30 days after its conclusion or, if the policyholder is an entrepreneur, within 7 days from the conclusion of the agreement. After this period, the policyholder has the right to terminate the agreement by a written notice. The Policyholder has the right to cancel the extension of the additional insurance by sending us a written notice of non-renewal no later than 30 days prior to its termination.

REMUNERATION FOR THE DISTRIBUTOR OF THE INSURANCE

The distributor shall receive a commission in connection with the proposed agreement.

COMPLAINTS, OBJECTIONS AND GRIEVANCES

1. A claim, complaint or grievance shall be submitted to any of our units where we serve our customers.
2. A complaint, grievance or complaint can be submitted:
 - 1) in writing – in person or by mail, within the meaning of the Postal Law Act, for example by writing to the following address: PZU Życie SA 18A Postępu St., 02-676 Warsaw (address for correspondence only);
 - 2) in writing – sent to the address for electronic delivery of PZU Życie SA, within the meaning of the Electronic Delivery Act, from the date of entering that address into the database of electronic addresses;
 - 3) verbally – by phone, for instance by calling the telephone helpline on 801 102 102, or in person, confirmed by means of a protocol during a visit to our unit;
 - 4) electronically – by sending an e-mail to reklamacje@pzu.pl or by filling in the form at www.pzu.pl.
3. We respond to complaints, grievances and complaints as soon as possible, however no later than 30 days after the day on which we receive them. If we are unable to respond in particularly complex cases within 30 days, we will inform you:
 - 1) why the response is delayed;
 - 2) what circumstances we still need to establish in order to process the case;
 - 3) what is the new time limit for our response – it may not exceed 60 days from the date on which we received the complaint, claim or grievance.
4. We respond to complaints, claims and grievances to the person who made them:
 - 1) in cases where the customer is a natural person – in writing, except that the response may be delivered by e-mail only at the customer's request;
 - 2) where the customer is an entity other than those referred to in item 1 – in writing or using another durable medium.
5. If, after the complaint has been investigated:
 - 1) we have not honoured the claims made or
 - 2) we have accepted the claim, but within the time limit specified in the reply to that claim we have not carried out the acts we obliged to take– the individual who has made a complaint has the right to write to the Financial Ombudsman to request this.
6. We deal with complaints, grievances and complaints in our units, which have authority over the subject matter.
7. Additional information on complaints are provided in the Act on Complaints Handling by Financial Market Entities and Financial Ombudsman and in the Act on Insurance Distribution.
8. PZU provides for the possibility of resolving conflicts out of court.
9. An entitled entity within the meaning of the Act on out-of-court settlement for PZU Życie to handle disputes out of court, is the Financial Ombudsman. The website address: rf.gov.pl.
10. In the event that the insured or the policyholder, beneficiary and the rights holder are consumers, they can turn to the Municipal and District Consumer Ombudsmen for assistance.
11. PZU communicates with its consumers in Polish.
12. PZU is supervised by the Financial Supervision Authority.



**GENERAL TERMS
ADDITIONAL GROUP INSURANCE FOREIGN
MEDICAL CONSULTATION AND ASSISTANCE
SERVICES**

The table below presents the provisions of the general terms and conditions of the additional group insurance Foreign Medical Consultation and Assistance Services, terms and conditions code KZGP55 (GTC), which govern the exclusion and limitation of the insurance company's liability.

These provisions constitute a part of the GTC, and their indications are a result of the legal regulations (Article 17, section 1 of the Insurance and Reinsurance Act).

No.	Type of information	Record number
1.	Conditions for benefit payment	items 1-5 items 7-70 item 98 items 99-108 item 109
2.	Restrictions and exemptions of the facility's liability insurance granting the right to refuse to pay benefits or their reduction	items 1-5 items 11-70 items 71-74 items 75-76 items 94-95 items 96-97 item 109

Information about the insurance are available from:

 na pzu.pl



at the phone number 801 102 102
(charged according to the operator's tariff)

GENERAL CONDITIONS FOR SUPPLEMENTARY GROUP INSURANCE FOREIGN MEDICAL CONSULTATION AND ASSISTANCE SERVICES



GTC code: KZGP55

The Board of Directors of PZU Życie SA set out the general terms and conditions of the additional group insurance foreign medical consultation and services by means of Resolution No. UZ/202/2021 of 9 November 2021 (hereinafter referred to as the GTC).

These General Terms and Conditions shall enter into force on 01 December 2021 and shall apply to insurance agreements concluded from 1 January 2022.

The policyholder shall read the GTC carefully before concluding the contract and communicate the GTC to anyone who wishes to take out insurance.

Please read the GTC you have received from your policyholder carefully before you take out insurance.

GLOSSARY

– i.e. what do the terms actually mean

1. the GTC uses the following terminology:

- 1) **Assistance Centre** – a centre which has been organised by the provider and which provides the services indicated in the supplementary insurance; the Assistance Centre is open 24 hours a day, 7 days a week;
- 2) **home** – the place in Poland where the insured or the co-insured is currently staying;
- 3) **child** – a child under 18 years of age. The child may be:
 - a) a child of the insured,
 - b) child of the insured's spouse or domestic partner (if the other parent of the spouse's or domestic partner's child is deceased);
- 4) **foreign consultant** – a foreign medical facility that the provider has appointed for medical consultation;
- 5) **medicine** – a finished medicinal product that:
 - a) has a valid authorisation issued by the President of the Office for Medicinal Products, Medical Devices and Biocidal Products, the Council of the European Union or the European Commission (according to the Pharmaceutical Law Act),
 - b) is entered in the Register of Medicinal Products Authorised in the territory of the Republic of Poland;
- 6) a doctor of the Assistance Centre - a person who, in accordance with Polish law, may practise medicine and who has signed a contract with a healthcare provider;
- 7) consultant physician - a doctor practising outside Poland, with a medical specialisation and professional experience appropriate to the specifics of the medical event in question, who prepares the foreign medical consultation;
- 8) **insurance protection period** – the period of time during which our liability to the insured under the supplementary insurance continues;
- 9) **childcare** – the care of children under 15 years of age or of dependent persons, which consists in ensuring their proper existence in terms of basic living needs and protection from dangers;
- 10) **a dependent person** – a person with whom you live who requires the constant assistance of another person in meeting the basic needs of life;
- 11) **medical facility** – an establishment within the framework of inpatient or outpatient public or private health care, which provides medical services in Poland and which has signed a contract with a healthcare provider;
- 12) **diagnostic and treatment procedure** – medical procedure consisting of the patient's medical history, physical examination of the patient and additional examinations to establish the diagnosis or medical procedure aimed at treatment;
- 13) **health problem** – a problem as a result of which you need our medical support, which can be provided as medical information, assistance in organising your treatment or daily activities;
- 14) **provider** – the entity that has contracted with us to organise the services we have indicated in the GTC;
- 15) **co-insured** – the spouse or life partner or child of the insured person;
- 16) **supplementary insurance** – the insurance agreement to which these GTC apply;
- 17) **basic insurance** – PZU Na Życie Plus group insurance agreement, to which the policyholder has the right to take out additional insurance;
- 18) **foreign medical consultation** – an opinion drawn up by a foreign consultant on the basis of the medical records of the insured or co-insured person, containing verification of the previous diagnosis, assessment of prognosis and treatment options and information on the professional experience and achievements of the consultant's doctor who drew it up;
- 19) **medical event** – the events during the period of cover listed under point 2 - basic coverage and under point 3 - extended coverage;
- 20) **insured event** – a medical event or health problem occurring during the period of cover.

2. Medical events covered in the basic scope:

- 1) **coronary artery angioplasty** – a method of percutaneous dilatation of a narrowed or obstructed section of a coronary artery;
- 2) **total inability to work and lead an independent life** – inability to perform any gainful employment in any occupation and the need for assistance from another person in meeting at least two of the basic necessities of life, which include washing, dressing, eating and moving about the house. We are responsible for such a total inability to work and lead an independent life, which is the result of an accident occurring during the PZU Życie SA liability period and which is permanent, i.e. according to the current medical knowledge, there are no positive prognoses for its recovery;
- 3) **total loss of speech** – permanent and irreversible loss of the ability to produce speech sounds and articulate intelligible language;
- 4) **a total loss of hearing in both ears** – which is an irreversible loss of hearing in both ears resulting in a bilateral hearing loss of at least 90dB (calculated as an average of the speech band sounds);
- 5) **surgical treatment of ischaemic heart disease (by-pass)** – a method involving the implantation of a bypass to bypass an obstructed or narrowed section of a coronary artery;
- 6) **surgical treatment of a valvular heart defect** – a method involving the treatment of a damaged own heart valve. We are only responsible for such surgical treatment of a valvular heart defect, which involves replacing the natural, pathologically altered heart valve with an artificial valve or a biological valve. A heart defect is understood to be an acquired anatomical abnormality in the structure of the heart valve function;
- 7) **severe disease of the reproductive organs** – inflammatory or neoplastic lesions of the reproductive organs requiring hospital treatment;
- 8) **severe trauma to the hand** – an injury which has resulted in the loss of the ability to make any precise movement of the hand;
- 9) **Alzheimer's disease** – progressive impairment of memory and other cognitive functions leading to dementia. We are only responsible for Alzheimer's disease resulting in dementia diagnosed by a specialist in neurology, psychiatry or geriatrics on the basis of documented clinical data and tests and questionnaires for the diagnosis of Alzheimer's disease. Our liability does not cover dementia caused by other diseases or dementia secondary to alcohol abuse, medication or AIDS;
- 10) **Crohn's disease** – chronic non-specific inflammation of the intestinal wall. We are only responsible for such Crohn's disease, which is confirmed by histopathological examination and in the course of which a fistula, abscess or intestinal stricture has developed;
- 11) **motor neurone disease (amyotrophic lateral sclerosis)** – which is a neurodegenerative disease of the peripheral and central nervous system caused by selective damage to motor nerve cells. We shall be only responsible for such motor neuron disease which has been diagnosed by a neurologist based on an electromyography (EMG) test and which has caused muscle weakness or atrophy and restriction of active movements;
- 12) **Parkinson's disease** – which is a neurodegenerative disease of the central nervous system caused by the loss of nerve cells that are important for motor function. We are only responsible for such Parkinson's disease which has been diagnosed by a neurologist and which has caused at least two of the following neurological symptoms:
 - a) resting tremor,
 - b) motor slowdown,
 - c) increased muscle tension;
- 13) **myelodysplastic diseases** – diseases of the haematopoietic system, characterised by abnormal differentiation and maturation of marrow cells, a reduction in the number of blood cells and morphological dysplasia of at least one haematopoietic cell line;
- 14) **diabetes** – a metabolic disease characterised by elevated blood glucose levels due to disturbances in the secretion or action of insulin. We are only responsible for such diabetes in the course of which nephropathy or diabetic retinopathy has occurred;
- 15) **carotid endarterectomy** – surgical operation to remove atherosclerotic plaques from the lumen of the common carotid artery or internal carotid artery;
- 16) **brain tumour** – any pathological lesion located within the brain. We are only responsible for such a brain tumour that increases in size and causes neurological symptoms of increased intracranial pressure;
- 17) **spinal cord tumour** – any pathological lesion located within the spinal cord. We are only responsible for such a spinal cord tumour that causes a neurological deficit and requires surgical treatment;
- 18) **cardiomyopathy** – a disease of the heart muscle caused by its primary damage. Our liability does not cover secondary cardiomyopathies in the course of ischaemic heart disease (coronary heart disease), arterial hypertension, pulmonary hypertension or heart defects;
- 19) **surgical treatment of epilepsy** – neurosurgical operation within the brain carried out to treat drug-resistant epilepsy;
- 20) **kidney failure** – acute or chronic renal failure. We are only responsible for such renal failure that required hospital treatment;
- 21) **malignant neoplasm** – which is an uncontrolled proliferation of cancer cells characterised by their ability to infiltrate and destroy tissues and form distant metastases. We are only responsible for such malignant tumours, the invasive nature of which has been confirmed by histopathological examination. We are also responsible for malignant tumours with metastatic lesions when material has not been taken for histopathological examination, but the clinical picture and diagnostic tests are unambiguous as to the malignancy of the neoplastic process.
- 22) **burns that cover a large area of the body** – localised damage to the skin and deeper-lying tissues caused by a thermal, chemical or electrical agent. We are only responsible for such severe burns that required hospitalisation and covered:
 - a) over 70% of the body surface – for 2nd degree burns only or
 - b) more than 70% of the body surface – for 2nd and 3rd degree burns combined, or
 - c) more than 15% of the body surface – for third-degree burns only;

- 23) **eye surgery** – surgery on the structures of the eyeball, the protective or motor apparatus of the eye; our liability does not cover surgery on cataracts or a defect in vision;
- 24) **surgical implantation of an artificial joint (prosthetics)** – removal of a joint or part of a joint and replacement with a prosthesis. Our cover includes surgical operation to implant an artificial joint in the upper limb or lower limb;
- 25) **end-stage organ failure** – end-stage failure of one or more of the following organs: heart, lung, liver, pancreas, kidney or bone marrow, which, without intensive treatment, leads to complete failure of that organ and death of the insured;
- 26) **multiple sclerosis** – a disease of the central nervous system with the presence of neurological defects arising from diffuse demyelinating lesions. We are only responsible for such multiple sclerosis that has been definitively diagnosed by a neurologist, based on neurological symptoms and magnetic resonance imaging, confirming the temporal and localised spread of demyelinating lesions in the central nervous system;
- 27) **coma** – a state of profound disturbance of consciousness, expressed by an inability to respond to external auditory or pain stimuli, resulting from severe brain damage. We are only responsible for such a coma that has lasted continuously for at least 96 hours and the brain damage has caused: neurological deficit or cognitive impairment of at least 30 days as assessed by the Brief Mental State Rating Scale test at less than 20 points.
- 28) **Transplantation** – which is the surgical operation of transplanting organs or tissues of human origin. We are only responsible for heart, kidney, liver, lung, pancreas and allogeneic bone marrow transplants performed on the recipient;
- 29) **stroke with permanent neurological loss** – a sudden, focal or generalised disruption of brain function caused exclusively by closure of the lumen of a cerebral vessel or interruption of its wall, which has resulted in permanent neurological loss. We are only responsible for a stroke with permanent neurological loss where:
 - a) brain imaging studies clearly confirmed fresh vascular lesions or the stroke was treated with thrombolytic therapy, and
 - b) a neurological examination, carried out 3 months after the stroke, confirmed the persistence of neurological loss in connection with the stroke.
- 30) **damage to the rotator cone** – damage to the muscle group stabilising the shoulder-scapula joint. We are responsible for such damage to the rotator cone that leads to the inability to perform active inversion, internal rotation or external rotation movements of the shoulder-scapula joint;
- 31) **loss of a limb** – which is the loss of all or part of a limb. We are only responsible for the loss of an upper limb above the elbow joint or the loss of a lower limb above the knee joint;
- 32) **viral hepatitis** – an infectious disease caused by the hepatitis virus. We are only responsible for such viral hepatitis, the diagnosis and aetiological agent of which are unequivocally confirmed by the medical documentation, and in the course of which jaundice and elevated enzymes indicative of liver damage occurred;
- 33) **congenital heart defect** – an anatomical abnormality of the heart, present from birth;
- 34) **ulcerative colitis** – chronic non-specific inflammation of the bowel wall. We are only responsible for such ulcerative colitis diagnosed by histopathology, and in the course of which pseudopolyposis of the intestine or colonic dilatation occurred;
- 35) **HIV infection** – human immunodeficiency virus infection, confirmed by serological tests.
3. Within the extended scope, PZU Życie SA covers with liability the medical events listed in point 2 and additionally:
 - 1) **a non-cancerous disease of the central nervous system in a child** – a disease of the brain, spinal cord or meninges diagnosed in the insured child. Our cover extends only to such non-cancerous disease of the central nervous system in a child that requires surgery;
 - 2) **congenital malformation of the child** – a deviation from normal anatomy, falling into categories Q00 to Q99 of the ICD-10 International Statistical Classification of Diseases and Related Health Problems, recognised in the child of the insured
 - 3) **congenital heart defect in a child** – an anatomical abnormality of the structure of the heart, present from birth and known in the child of the insured.
4. In the basic scope, we cover the insured. In the extended coverage, we cover the insured and co-insured.
5. The other terms used in these GTC are defined in the general terms and conditions of the basic insurance – the same terms retain the same meaning.

OBJECT OF INSURANCE

–what do we insure

6. We insure the health of:
 - 1) the insured person – in the basic scope or
 - 2) the insured and the co-insured – in the extended scope.

ZAKRES UBEZPIECZENIA I ŚWIADCZENIA Z TYTUŁU UMOWY

– w jakich przypadkach i jakie usługi zapewniamy

7. Supplementary insurance covers the occurrence of an insured event.
8. In the event of a medical event, we enable the insured or co-insured (in accordance with the coverage chosen by the insured in the declaration of accession) to provide the services specified in 9(1) during our period of cover.
9. Supplementary insurance in both scopes covers the occurrence during the period of our coverage:
 - 1) medical events resulting in a benefit under:
 - a) foreign medical consultation
 - b) Assistance Services,
 - c) Assistance in Treatment Planning
 - d) 24-hour Medical Telephone Service or

- 2) a health impairment resulting in a service under the 24-hour Medical Helpline.
10. A list of benefits with their descriptions can be found below.

FOREIGN MEDICAL CONSULTATION

11. In the case of a medical event, we make it possible for the insured or co-insured (in accordance with the scope selected by the insured in the declaration of affiliation) to receive a foreign medical consultation during the period of our liability.
12. We provide the following services through a healthcare provider – if a medical event occurs:
- 1) we provide the insured or co-insured person with information on the medical records on the basis of which the foreign consultant issues a foreign medical consultation;
 - 2) we translate medical records into the language used by the foreign consultant;
 - 3) we transfer the medical records to the foreign consultant;
 - 4) we provide for the issue of a foreign medical consultation by a foreign consultant;
 - 5) we translate a foreign medical consultation into Polish;
 - 6) we provide the insured or co-insured person with a foreign medical consultation – in the form of a written opinion.
13. The insured or co-insured can benefit from one overseas medical consultation for one medical event. If new examinations show changes in the course of this medical event, the insured or co-insured can request another foreign medical consultation.

ASSISTANCE SERVICES

14. The following services are organised by the Assistance Centre – if an insured or co-insured person suffers a medical event. Unless we have indicated otherwise, they are available from 8 a.m. until 10 p.m. at the latest – at home or elsewhere in Poland that we agree with the insured or co-insured or with a person designated by the insured. The agreed location must enable the service to be provided. These include:
- 1) the provision of essential medicines – around the clock (see items 17-21);
 - 2) provision of rehabilitation equipment (see items 22-25);
 - 3) home care by a nurse (see items 26-29);
 - 4) caring for small pets (see items 30-35);
 - 5) childcare (see items 36-41);
 - 6) assistance with housekeeping (see items 42-47);
 - 7) handing over personal effects for repair (see items 48-53);
 - 8) medical transport - around the clock and nationwide (see items 54-58);
 - 9) home visit by a psychologist (see items 59-61);
 - 10) home visit by a physiotherapist or masseur (see items 62-64).
15. The services we have indicated above are available to the insured or co-insured during our period of cover for one medical event – a particular service can only be arranged once, taking into account the medical transport provisions indicated in paragraphs 54 to 58.
16. In relation to the co-insured, the Assistance Centre organises the benefits according to the insured's choice.

Provision of essential medicines

17. The Assistance Centre organises and covers the costs of the service if, due to the insured's or the co-insured's health condition, he or she has to stay at home for at least 5 days on sick leave issued by the insured's treating doctor.
18. We supply medicines, according to the prescriptions issued to the insured or co-insured person, as long as the medicines are available in Poland and the insured or co-insured makes the prescription available to the Assistance Centre. If the insured person needs over-the-counter medicines that are also available at the place where the prescription is filled, we will also carry out the supply of the over-the-counter medicines indicated by the insured person.
19. During the period of sick leave, this service is available to the insured or the co-insured once – however only if there is no person at home to provide such service.
20. Necessary medicines will be purchased at a location to be indicated by the insured or the co-insured, provided that the distance to this location is no greater than the distance to the place of purchase to be selected by the Assistance Centre, taking into account their availability at that location.
21. The insured or co-insured shall pay the cost of the medicines

Provision of rehabilitation equipment

22. The Assistance Centre organises and covers the costs of the service if, due to the insured's or the co-insured's health condition, he or she has to stay at home for at least 5 days on sick leave issued by the insured's treating doctor.
23. The Assistance Centre will provide purchased or rented equipment based on prescriptions or written recommendations from the insured's or the co-insured's treating physician.
24. During the period of sick leave, this service is available to the insured or the co-insured once – however only if there is no person at home to provide such service.
25. The insured or the co-insured covers the costs of purchasing and renting rehabilitation equipment.

Home care by a nurse

26. The Assistance Centre organises and pays for the nurse's travel and fees.
27. The nurse's care for the insured consists of activities:
- 1) related to hygiene and nutrition (excluding food preparation);
 - 2) nursing interventions – as ordered by the doctor – such as performing compresses, dressings, respiratory rehabilitation, therapeutic exercises, measuring blood pressure and pulse, weighing.

28. The Insured or the co-insured shall pay the costs of medical devices and medicinal products used in the aforementioned activities.
29. The service lasts up to eight hours a day for two weeks or up to four hours a day for four weeks. The care type is indicated by the insured person in the application for the organisation of the service and he/she cannot change his/her choice. It can divide the eight-hour care into two blocks of time of four hours each. If the insured chooses the four-hour option, he or she cannot divide this period into a shorter one.

Care for small domestic animals

30. The Assistance Centre organises and pays for the service – but only if the following conditions are all met:
 - 1) the animals are housed and do not pose a threat to the health of the carers or the safety of the environment – in the opinion of the carer. Care can involve animals such as reptiles, rodents, cats, insects, amphibians, dogs, birds and fish;
 - 2) they are not animals of species or breeds that are considered – in particular by legislation – to be hazardous;
 - 3) there is no person in the household who can take care of them;
 - 4) the insured or a co-insured or a person nominated by the insured person shall produce a document which proves that the required animal vaccinations have been carried out.
31. If the insured or the co-insured is not at home, the service may be provided under the condition that he or she has given written consent to the service and that home access was provided by the insured person or the co-insured and the persons who remain inside.
32. Animal care includes:
 - 1) provision of food. The food will be purchased at a location that the insured or the co-insured person indicates, provided that the distance to them is no greater than the distance to the place of purchase that the Assistance Centre chooses;
 - 2) cleaning activities;
 - 3) providing temporary care for the animal.
33. The Assistance Centre covers the carer's travel costs and fees. The insured or the co-insured covers the remaining costs, i.e. feed, veterinary care, vaccinations, for example.
34. The service lasts up to eight hours a day for two weeks or up to four hours a day for four weeks. The care type is indicated by the insured person in the application for the organisation of the service and he/she cannot change his/her choice. It can divide the eight-hour care into two blocks of time of four hours each. If the insured chooses the four-hour option, he or she cannot divide this period into a shorter one.
35. Each hour of care started for small pets is counted as one hour.

Childcare

36. The Assistance Centre organises and covers the costs of medical transport – but only if:
 - 1) there is no person at the children's place of residence who can take care of them, and
 - 2) the insured person gives his or her written consent to this care and indicates the dates of the care.
37. In the childcare service, it is necessary to contact the insured or the person he or she indicates. If we do not contact the insured or a nominated person and we do not obtain the insured's written consent, we do not undertake the service.
38. We need to know if the children require special care – for instance, they have a chronic illness, require rehabilitation, are taking medication or are on a special diet. Such information – in writing – must be provided to us by the person requesting the service.
39. The Assistance Centre covers the carer's travel costs and fees. The insured or the co-insured shall cover all the remaining costs of care.
40. The service lasts up to eight hours a day for two weeks or up to four hours a day for four weeks. The care type is indicated by the insured person in the application for the organisation of the service and he/she cannot change his/her choice. It can divide the eight-hour care into two blocks of time of four hours each. If the insured chooses the four-hour option, he or she cannot divide this period into a shorter one.
41. Each hour of care started for a small child is counted as one hour

Assistance in housekeeping

42. The Assistance Centre arranges and pays for the travel expenses and fees of a home helper – if there is no person in the home to provide this service and the insured person is present at home.
If the insured or the co-insured is not at home, the service may be provided under the condition that he or she has given written consent to the service and that home access was provided by the insured person or the co-insured and the persons who remain inside.
43. Domestic assistance to the insured includes:
 - 1) housekeeping, i.e.: dry cleaning of floors, wet cleaning, dust removal from furniture, windowsills, vacuuming of carpets, carpets, cleaning of bathroom ceramics, bath tub, shower cabin, washing up, cleaning of sink, hob;
 - 2) preparation of meals, including for children or dependants;
 - 3) making the purchases necessary to carry out the activities indicated in points 1 and 2;
 - 4) watering the flowers;
 - 5) waste disposal
– using means or equipment that are made available by the insured or the co-insured person.
44. The insured or co-insured covers the cost of purchases.
45. Purchases necessary for the service shall be made at the places indicated by the insured or the co-insured person, provided that the distance to them is not greater than would be the distance to the place of purchase selected by the Assistance Centre.
46. Housekeeping assistance service is available for up to eight hours a day for a fortnight, or up to four hours a day for four weeks – if the insured or co-insured does not live at home with someone who can help with this. The care type is indicated by the

insured person in the application for the organisation of the service and he/she cannot change his/her choice. It can divide the eight-hour care into two blocks of time of four hours each. If the insured chooses the four-hour option, he or she cannot divide this period into a shorter one.

47. Each hour of housekeeping assistance started is counted as one hour.

Handing over personal effects for repair

48. The Assistance Centre organises and covers the costs of the service if, directly due to the insured's health condition, the insured has to stay at home for at least 5 days on sick leave issued by the insured's treating doctor.
49. The service consists of delivering the following personal items for repair:
- 1) hearing aid;
 - 2) apparatus for measuring blood pressure;
 - 3) rehabilitation walkers;
 - 4) walker;
 - 5) braille printer;
 - 6) glucometer;
 - 7) inhaler;
 - 8) oxygen concentrator;
 - 9) electronic larynx;
 - 10) rehabilitation bed;
 - 11) air mattress;
 - 12) air humidifier;
 - 13) nebuliser;
 - 14) glasses;
 - 15) parapodium;
 - 16) verticaliser;
 - 17) picoflometer;
 - 18) lift;
 - 19) infusion pump;
 - 20) insulin pump;
 - 21) prosthesis;
 - 22) respirator;
 - 23) mammal;
 - 24) speech synthesiser;
 - 25) massage device;
 - 26) wheelchair.
50. The Assistance Centre delivers the items from the home to a repair centre in Poland that the insured person indicates and delivers them back home.
51. Personal effects will be delivered to a repair point at a location to be indicated by the insured or the co-insured, provided that the distance to it is not greater than the distance to the repair point chosen by the Assistance Centre.
52. The insured or co-insured shall pay the cost of repairing personal items.
53. During the period of sick leave, the service of providing items for personal use is available to the insured or co-insured once – but only if there is no person at home to provide this service.

Medical transport

54. The Assistance Centre organises and pays the costs of medical transport of the insured or co-insured. The decision on the choice of time, destination and means of transport is taken by the Assistance Centre after consultation (if medically justified) with the Insured's doctor, taking into account the Insured's state of health, the means of transport available and the time and purpose of transport.
55. Medical transport is available to the insured or co-insured:
- 1) to the hospital which is nearest to the place of stay and which is adequately equipped to provide assistance, or
 - 2) to another medical facility – insofar as the state of health of the insured or co-insured person makes such transportation possible – and
 - 3) to the home of the insured or co-insured – after discharge from hospital or another medical facility.
56. Medical transport takes place in Poland under the necessary medical supervision and using the necessary means of transport.
57. The Assistance Centre shall not provide the service if the insured or co-insured takes action contrary to the advice of the Assistance Centre doctor.
58. For one medical event, the insured or co-insured is entitled to the medical transport service a maximum of two times (in total for the services indicated in item 55).

Psychologist home visit

59. The Assistance Centre arranges and covers the cost of visits – if the insured or co-insured's mental health deteriorates due to the insured or co-insured's medical condition.
60. The insured or co-insured is entitled to one psychologist visit per day – lasting up to 2 hours. Visits can take place up to four weeks from the first visit, but no longer than the psychologist deems necessary.
61. Each commenced hour of a psychologist's visit is counted as one hour.

Home visit by a physiotherapist or masseur

62. The Assistance Centre organises and pays the costs of visits – if rehabilitation is needed in connection with the insured's or co-insured's state of health and on the basis of a medical referral.
63. The insured or co-insured person is entitled to one visit from a physiotherapist or massage therapist per day – lasting up to 2 hours. Visits can take place for up to four weeks from the first visit, but no longer than the physiotherapist or massage therapist deems necessary.
64. Each commenced hour of a visit by a physiotherapist or massage therapist is counted as one hour.

POMOC W PLANOWANIU LECZENIA

65. During the term of the supplementary insurance, the insured or co-insured can benefit from the following services – if a medical even occurs:
 - 1) Assistance in treatment planning;
 - 2) Assistance in treatment execution.
66. Within the scope of assistance in treatment planning, the Assistance Centre:
 - 1) searches its database for a Polish medical facility where the insured or co-insured person can receive health services such as surgery, diagnostic tests or a visit to a specialist in the shortest possible time, if ordered by the doctor treating the insured or co-insured person;
 - 2) shall provide the insured or co-insured person by telephone with information on the name, address, telephone number of the Polish establishment where the insured or co-insured person can obtain health care services most rapidly and on the dates of such services.
67. As part of helping to organise treatment, the Assistance Centre:
 - 1) arranges health care services such as nursing, medical consultations, rehabilitation – in Polish medical facilities (from its base) or at the home of the insured or co-insured, or
 - 2) provide information on services, opening hours and contact details of Polish medical facilities, especially those closest to the insured or co-insured person's home.
68. In order for the Assistance Centre to provide this service, it must obtain information from the insured or co-insured about the type of specialised health service their condition requires.

24-HOUR TELEPHONE MEDICAL SERVICE

69. If an insured or co-insured person suffers an insured event during the period of insurance, they can use our 24-hour Medical Telephone Service.
70. As part of the provision of the 24-hour Telephone Medical Service, we provide information on:
 - 1) manner of procedure in case of an accident, organise first aid and plan treatment;
 - 2) medical facilities where the insured person will be able to receive a health service such as first aid, a surgical procedure, a diagnostic test or an appointment with a specialist in the shortest possible time, and shall provide contact details of such facilities;
 - 3) the services available in medical facilities (hospitals, clinics, outpatient clinics, specialist departments) in Poland, including in particular those closest to home, their area of specialisation, opening hours and contact details;
 - 4) health, illness and disease entities;
 - 5) health-promoting behaviour;
 - 6) hospitals, pharmacies, clinics – located in Poland;
 - 7) infant care;
 - 8) medicines and the side effects of taking them;
 - 9) diets, healthy eating;
 - 10) support groups, helplines – providing assistance and available in Poland;
 - 11) medical transport in Poland;
 - 12) caring for the elderly.

EXCLUSIONS OF PROTECTION

– cases in which we are not going to pay out the benefit

71. Our liability does not cover medical events that have occurred:
 - 1) during war operations;
 - 2) as a result of the active participation of the insured or co-insured in acts of terror or mass civil unrest;
 - 3) as a result of the attempted or committed act by the insured or co-insured which fulfils the statutory elements of an intentional crime;
 - 4) when the insured or co-insured person was intoxicated within the meaning of the law on rearing to sobriety and counteracting alcoholism or after using: drugs, narcotics, psychotropic substances or substitutes - within the meaning of the regulations on counteracting drug addiction - if it influenced the occurrence of an insured event;
 - 5) as a result of self-harm by the insured or co-insured or attempted suicide by the insured or co-insured;
 - 6) directly as a result of intoxication by alcohol, drugs, narcotics, psycho-tropic substances or substitutes – within the meaning of the regulations on counteracting drug addiction;
 - 7) as a result of the use of medicinal products by the insured or co-insured not in accordance with the doctor's recommendation or not in accordance with the information in the leaflet accompanying the medicinal product.

72. Our liability does not cover:
- 1) services which the Assistance Centre has arranged because the insured or co-insured has given an untruth, in which case the cost of those services shall be borne by the insured or the co-insured;
 - 2) life-threatening incidents and consequences.
73. We are not responsible for the course or outcome of the Assistance Services we have listed in Section 14.
74. We are not responsible for the content of a foreign medical consultation.

GRACE PERIOD

– the period of the lack of or limited liability of the insurance company after you have taken out supplementary insurance

75. We are not liable to the insured or co-insured for the first 30 days counted from the date the insured joins the supplementary insurance.
76. During the grace period you can use:
- 1) 24-hour Medical Telephone Service or
 - 2) overseas medical consultation, provided that the medical event was the result of an accident occurring within these 30 days.

PREMIUM

– what does it depend on and when to pay it

77. Amount of the premium per the insured:
- 1) takes into account the grace periods that apply in supplementary insurance;
 - 2) it is fixed, but may be changed by mutual agreement;
 - 3) it depends on:
 - a) insurance coverage,
 - b) the number, age structure and gender of those who take out insurance, as well as the type of work they do.
78. The amount of the premium applicable to the additional insurance agreement is specified in the application for conclusion of the agreement as well as in the policy.
79. The policyholder pays us the premiums for the supplementary insurance on a monthly basis, together with the premium for the primary insurance.

TAKING OUT AND JOINING SUPPLEMENTARY INSURANCE

– i.e., How do we insure you

80. Supplementary insurance may be taken out either with or during the conclusion of the basic insurance.
81. The additional insurance may be joined by insured persons who joined the basic insurance.
82. The policyholder may take out additional insurance:
- 1) in one of two scopes, i.e. basic or extended, or
 - 2) in two scopes simultaneously, i.e. basic and extended.
83. In the case referred to in point 82 subsection 1 – the policyholder may change to a different scope at any time. The policyholder shall submit an application in order to change the scope of insurance. The new coverage shall be effective beginning from the 1st day of the month following the month of application.
84. In the case referred to in paragraph 82(2) – the insured can choose and change to a different coverage at any time. If you change coverage, the coverage period for the previous coverage ends on the last day of the month after which the coverage period for the new coverage begins. The new coverage is effective from the 1st of the month following the month in which the change was notified.

DURATION OF SUPPLEMENTARY INSURANCE

– i.e., which period we take out the supplementary insurance for

85. The policyholder may take out supplementary insurance with us for a limited period. We confirm the duration of the additional insurance in the policy. If the additional insurance is taken out between policy anniversaries, our cover continues until the next policy anniversary.

EXTENSION OF SUPPLEMENTARY INSURANCE

– what are the rules for extending supplementary insurance

86. Unless otherwise agreed by either party to the contract and provided that the primary insurance is in force, the supplementary insurance shall be automatically extended for the next policy year – under the same conditions. In this case, as an insured, you do not have to re-submit the declaration of membership.
87. Either party has the right to cancel the extension of the supplementary insurance, of which it shall notify the other party in writing. This must be done at the latest 30 days before the termination of this insurance.

WITHDRAWAL FROM SUPPLEMENTARY INSURANCE

– i.e. the conditions under which a policyholder may withdraw from the supplementary insurance

- 88. The cancellation of the additional insurance is carried out in accordance with the rules laid down in the basic insurance.
- 89. If the policyholder cancels the primary insurance, this results in cancellation of the secondary insurance.
- 90. If the policyholder withdraws from the additional insurance, this does not result in withdrawal from the primary insurance.

TERMINATION OF SUPPLEMENTARY INSURANCE

– i.e. the manner in which the policyholder can cancel the supplementary insurance

- 91. The termination of the supplementary insurance is carried out in accordance with the rules outlined in the basic insurance.
- 92. In the event the policyholder terminates the primary insurance, this results in the termination of the additional insurance.
- 93. If the policyholder terminates the additional insurance, this does not result in termination of the primary insurance.

THE BEGINNING OF OUR PROTECTION

– When our insurance protection starts

- 94. Coverage under the supplementary insurance commences as described in the basic insurance.
- 95. Cover under the additional insurance shall only commence if the cover under the basic insurance is in force.

THE CESSATION OF OUR PROTECTION

– i.e. when the supplementary insurance ends

- 96. Co-insurance cover in respect of the insured shall end:
 - 1) from the date of termination of cover under the primary insurance;
 - 2) from the date on which we receive the policyholder's declaration that he or she is withdrawing from the additional insurance;
 - 3) on the date of termination of cover under the supplementary insurance – if not renewed;
 - 4) on the last day of the month in which you cancel the supplementary insurance;
 - 5) at the end of the month of the supplementary insurance on the current terms and conditions, if you have not given the required consent to change the supplementary insurance;
 - 6) as from the date of expiry of the notice period of the supplementary insurance;
 - 7) as from the date on which the supplementary insurance is terminated.
- 97. Co-insurance cover in respect of the co-insured shall end:
 - 1) from the date of termination of cover for the insured under the primary insurance;
 - 2) on the date of termination of cover for the insured in the supplementary insurance;
 - 3) on the policy anniversary date falling in the year in which the spouse or life partner turns 18;
 - 4) on the policy anniversary date falling in the year in which the spouse or life partner turns 70;
 - 5) the death of a co-insured person;
 - 6) on the last day of the month in which we received notification of the dissolution of the marriage to the primary insured,
 - 7) on the last day of the month in which we receive notification that the insured has changed from extended to basic coverage.

PERSONS ENTITLED TO OBTAIN THE BENEFIT

– who the benefit is due to

- 98. Benefits are provided to the insured or co-insured.

PROVISION OF THE HEALTH BENEFIT

– or how to start using the benefits

Foreign Medical Consultation

- 99. The insured or co-insured to use this service, submits to the provider during the period of our coverage:
 - 1) request for a foreign medical consultation;
 - 2) medical records of the diagnostic and therapeutic procedure, the medical event;
 - 3) additionally in the case of co-insured persons:
 - a) spouse – marriage certificate,
 - b) a child – birth certificate;
 - 4) any other documents requested by you or requested by the healthcare provider.
- 100. If the documents we have requested are in a language other than Polish, the insured must provide us with a translation into Polish. This translation must be carried out by a sworn translator.

101. In order for a co-insured person to benefit from a foreign medical consultation, he or she is required to consent to the processing of personal data. If you do not consent to the processing of your co-insured's personal data, we cannot provide this service.
102. We perform the service through a health care provider.
103. We will carry out the service no later than 30 days from the day we receive the application and set of documents from the insured or co-insured. We may extend this time if – for objective reasons – we cannot determine within 30 days whether the insured or co-insured person is entitled to the service. In this case, we will carry out the service up to 14 days from the day on which, with due diligence, we clarify these doubts.

Usługi Assistance, Pomoc w Planowaniu Leczenia, Całodobowy Telefoniczny Serwis Medyczny

104. The Assistance Centre performs services under Assistance Services, Treatment Planning Assistance and 24-hour Medical Telephone Service only when requested by the insured or co-insured over the telephone. You will find the telephone number in the declaration – the service is open 24 hours a day. The Assistance Centre will start organising the service as soon as possible and no later than 48 hours after the insured or co-insured person has fulfilled the necessary conditions.
105. When applying over the phone, the insured or co-insured:
- 1) shall state the name, surname, PESEL of the insured and the name and place of business of the policyholder;
 - 2) gives all the information that is needed for a particular service, e.g.: telephone number, address, contact person;
 - 3) sends to the Assistance Centre – by fax, e-mail or post – medical documentation which confirms that a medical event has occurred or that a service is needed. This does not apply to the services of the 24-hour Medical Telephone Service;
 - 4) follow the instructions of the Assistance Centre.
106. A representative of the Assistance Centre may – at the place where the service is provided – ask for:
- 1) a presentation of a document proving the identity of the insured or co-insured person;
 - 2) providing the data necessary for the performance of the service, including all information to assess the state of health and the appropriateness of medical transport.
107. Neither the Assistance Centre nor we will reimburse the insured or co-insured if the incident has not been reported to the Assistance Centre. The exception is when the insured or co-insured has been unable to contact the Assistance Centre for reasons beyond their control. In this case, it is imperative that the insured or co-insured contact the Assistance Centre as soon as possible – they have 7 days to do so.
- The insured and co-insured should notify the Assistance Centre of the medical event and describe the reasons why they cannot be contacted. In this case, the insured or co-insured shall be reimbursed for the service provided – but up to a maximum of the average value of a given service in a given locality. In order to be reimbursed, the insured or co-insured shall submit the relevant documents: medical documentation proving that the insured or co-insured has suffered the medical event in question, named bills and proof of payment.
108. The insured or co-insured can also make their statements, notifications and other notifications by telephone – we record all telephone calls you make to the Assistance Centre. We will file all statements and notices of the insured or co-insured property with the Assistance Centre

FINAL PROVISIONS

– what other matters are important

109. Any matters not regulated by the supplementary insurance shall be subject to the general terms and conditions of basic insurance, the provisions of the Civil Code, the Act on Insurance and Reinsurance Activity and any other applicable laws.