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TERMS AND CONDITIONS

INDIVIDUAL TERM LIFE AND CRITICAL ILLNESS INSURANCE

#TLCI-001/25

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TBC INSURANCE

Definition of Terms

For the purposes of this insurance, terms used herein shall have the following meaning:

INSURER
JSC "TBC Insurance".

POLICYHOLDER
Natural person, who is responsible for the premium payment.

INSURED
In case of Life Insurance, a natural person who is between 20 and 55 years of age, a citizen of Georgia , and whose life is **insured** under the present Terms & Conditions.

In case of Critical Illness Insurance, a citizen of Georgia (Natural Person) who is between 18 and 60 years of age and his/her child/children who are between one and 18 years of age and are indicated in the **Insurance Policy**. Children **under the age of 18 can only be insured under a parent's policy**.

For the purposes of both, Life and Critical Illness Insurances, the **Policyholder** and the **Insured** are one and the same person.

BENEFICIARY
Person entitled to receive Insurance **Indemnification** and/or medical services upon occurrence of the **Insured Event** within the scope of this insurance.

Under Life Insurance section, **Beneficiary** shall be legal heir(s) of the **Insured**, unless a **Beneficiary** is designated by the **Insured** on the Policy. If by the time of the **Insured Event**, named **Beneficiary** is no longer alive, the **Beneficiary(ies)** shall be legal heir(s) of the **Insured**.

Under Critical Illness section, **Beneficiary** shall be the **Insured**. If by the time of the **Insured Event**, the **Insured** in no longer alive, Insurance **Indemnification** shall be paid to his/her legal heir/heirs.

INSURANCE POLICY
Document certifying conclusion of the **Contract of Insurance** between the **Insurer** and the **Policyholder** and stating details of the insurance cover. In case of any discrepancy between the Policy and present Terms and Conditions, the Policy shall prevail.

INSURANCE PREMIUM
Cost of insurance to be paid by the **Policyholder** in the amount and form as specified in the **Insurance Policy**.

INSURANCE EVENT
Event that occurs during the **Period of Insurance**, after expiration of **waiting period** and/or **survival period** (if such is envisaged by the appropriate coverage), and caused by the **Insured Risk**, which triggers **Insurer's** liability to indemnify the claim.

INDEMNIFICATION
Amount payable by the **Insurer** to the **Beneficiary** upon occurrence of the **Insured Event**.

PERIOD OF INSURANCE
Period of time indicated in the Insurance Policy during which insurance coverage is valid.

Period of Insurance is specified in the Insurance Policy.

CONTINUOUS RENEWAL
Renewal of a current policy on the next calendar day after its expiry/termination date.

SUM INSURED / LIMIT
Amount indicated in the Policy, within which Insurance Indemnification is paid.

CURRENT SUM INSURED PER INSURED
Sum Insured remaining after the previous/last claim/s payment.

INSURED RISK
Events and services that constitute an Insured Event and that are selected by the Policyholder and indicated in the Policy.

TERRITORY OF COVER
Worldwide, except for Iraq, Afghanistan, Somalia, and all other territories where hostilities are taking place.

DEATH
Death either by natural causes or due to Personal Accident (except for cases provided for in the Exclusions Clause).

PERSONAL ACCIDENT
Sudden and unexpected event caused by visible external force(s), which causes death of the Insured.

ATTENDING PHYSICIAN
Duly certified and licensed physician who has diagnosed critical illness and who is in charge of treating the Insured. The Insured cannot act as an Attending Physician.

DIAGNOSIS/DIAGNOSIS MADE
Conclusion on the state of health produced by the Attending Physician in compliance with the state standards and clinical criteria, indicating exact name of the Critical Illness/health condition, international code (ICD-10), form and stage in accordance with appropriate international classification (in case of cancer).

CONFIRMATION OF DIAGNOSIS
Confirmation/Verification of the Diagnosis Made according to the international protocols and specific criteria stated in the Insurance Policy Terms and Conditions. In case of malignant tumors, diagnosis must be confirmed by the histomorphological examination.

CONTRACT OF INSURANCE
Contract of Insurance consists of a declaration/questionnaire, an Insurance Policy issued based on the information contained in the declaration/questionnaire, Key Conditions Document and present Terms and Conditions.

PRE-EXISTING ILNESS/PATHOLOGICAL CONDITION

For the purposes of Life Insurance, disease and/or health condition which was diagnosed/occurred prior to the conclusion of the **Contract of Insurance** or prior to expiration of the **waiting period**.

For the purposes of Critical Illness Insurance:

- Critical Illness diagnosed and/or clinical examination undertaken prior to the conclusion of the **Contract of Insurance** or prior to expiration of the **waiting period**.
- Examinations initiated/started/conducted prior to the conclusion of the **Contract of Insurance** or prior to expiration of the **waiting period**, based on which the covered critical illness was diagnosed/the need for a covered intervention was determined;
- Medical examinations conducted/ongoing prior to the conclusion of the Insurance Contract, which the **insurer/insured** did not declare prior to/during the conclusion of the **Insurance Policy**.

For Critical Illness Insurance purposes, in case of pre-existing illness/condition, the **Contract of Insurance** shall be cancelled, and the **Insurer** shall be free from any liability to indemnify the claim

MEDICAL RECORDS

Documents pertaining to health condition of the **Insured**, produced by the **Attending Physician** and/or other appropriate representative of the healthcare/medical institution in compliance with the state standards. The documentation should include final diagnosis/diagnoses, results and conclusions of physical, laboratory, instrumental and other examinations/tests and recommendations for treatment.

WAITING PERIOD

Period of time during which no **indemnification** shall be paid by the **Insurer** if the following circumstances/events occur:

1. For the Individual Term Life insurance purposes:

- Illness diagnosed and/or a health condition/problem occurred and/or the **death** of the **insured**.

2. For the Critical Illness insurance purposes:

- Illness, which is covered under the **insurance policy**, is diagnosed;

- Examinations, on the basis of which the covered critical illness is diagnosed/the need for a covered intervention is determined, have been initiated/started/conducted;

Waiting Period is set as 120 (One hundred and twenty) calendar days and is calculated from the Policy inception date.

Waiting period shall not apply to accidental **death** risk.

SURVIVAL PERIOD

Period from the date of diagnosis of a critical illness/undergoing the covered intervention during which the **Insured** must stay alive. If **Insured** dies during the **Survival Period**, Insurance **Indemnification** shall not be paid.

Survival Period is set as 30 (thirty) calendar days from the date of diagnosis/undergoing the covered intervention and applies to the following critical illnesses/interventions only: myocardial infarction, non-malignant brain tumor, heart valve surgery, major organ transplant, stroke, and Coronary Artery Bypass Surgery.

RISKS INSURED | IMPORTANT INFORMATION | EXCLUSIONS

1. SUBJECT MATTER OF INSURANCE

1.1. This insurance provides for payment of Insurance **Indemnification** to the **Beneficiary** upon occurrence of the **Insured Event** caused by the **Insured Risk** as indicated in the **Insurance Policy**, except as provided in the Exclusions Clause.

2. INSURANCE PROCEDURE

2.1. **Persons eligible for insurance:**

2.1.1. **Persons eligible for life insurance:**

Citizen of Georgia, who is between 20 and 53 years at the time of insurance.

2.1.2. **Persons eligible for critical illness insurance:**

Citizen of Georgia, who is between 18 and 59 years at the time of insurance and his/her child/children aged between one and 17.

2.2. **Who is not eligible:**

2.2.1. Persons in need of daily care (assistance in daily activities);

2.2.2. Persons who have been diagnosed with such disease(s), anatomical and/or mental defect(s) that constitute the basis for establishing the status of a clearly expressed disability in accordance with the Order No. 1/N of the Minister of Labor, Health and Social Protection of Georgia of January 13, 2003;

2.2.3. In respect of Life Insurance, individuals already **insured** under the **Insurer's** and/or other insurance companies' voluntary Term Life insurance product, without prior approval of the **Insurer**;

2.2.4. In respect of Critical Illness Insurance, individuals already **insured** under the **Insurer's** Critical Illness insurance product, without prior approval of the **Insurer**;

2.2.5. In respect of Critical Illness Insurance, individuals already **insured** under other insurance companies' Oncology Diseases/Critical Illness insurance product, without prior approval of the **Insurer**.

2.3. To purchase insurance, prospective Insured shall fill out a digital questionnaire/declaration. Based on the information provided in the questionnaire/declaration, as well as any other information provided by the prospective Insured by any other means prior to the conclusion of the Contract of Insurance, the Insurer decides whether to insure a person and on what terms and conditions. The questionnaire/declaration/provided information form an integral part of the Contract of Insurance. If information provided by the prospective Insured via questionnaire/declaration and/or any other means is incorrect, inaccurate, incomplete, false, or misleading, the Insurer has the right to refuse to pay the claim indemnification and/or render insurance services and to cancel the Contract of Insurance.

2.4. Based on the documentation and/or information provided via the questionnaire /declaration and/or any other means as well as results of medical tests and examinations, the Insurer decides whether to insure a person under standard or special terms, postpone decision upon the insurance or to refuse a cover. If insurance is offered on special terms, such shall be indicate in the Policy.

2.5. By purchasing insurance under present Terms and Conditions, the **Policyholder** agrees and authorizes the **Insurer**, upon occurrence of the **Insured Event**, to request **medical records** and other medical information from any medical institution and/or any third party, along with personal information that is necessary to establish circumstances of the **Insured Event**.

2.6. For the purposes of Life Insurance, **Waiting Period** in respect of the risk of **death** due to natural causes shall not apply to **Insureds** who had been **insured** under the **Insurer's** voluntary Term Life insurance product and who have continuously purchased/renewed the cover for the same or lesser limit, provided that **Waiting Period** under the previous policy has been expired by the time of purchase/renewal.

2.7. For the purposes of Critical Illness Insurance, **Waiting Period** shall not apply to **Insureds** who were **insured** under the **Insurer's** Critical Illness insurance with the same or lesser limit and who have continuously purchased/renewed the cover under present Terms and Conditions, provided that **Waiting Period** under the previous policy has been expired by the time of purchase/renewal.

2.8. If there is a lapse between the Policy cancellation/expiry and the renewal dates and **Waiting Period** is not expired by the time of purchase/renewal or the limit under the new policy is increased, **Waiting Period** shall apply to the new/renewed Policy.

2.9. In case of Critical Illness Insurance, **Waiting Period** shall not apply if the **Insured** Child upon turning 18 has continuously concluded a separate **Contract of Insurance** with the **Insurer**, with identical coverage.

3. INSURED RISKS AND BENEFITS

This insurance envisages:

3.1. **In case of term life insurance:**

3.1.1. Payment of Sum **Insured** as specified in the Policy in the event of the **Insured's death** during the **Period of Insurance** and after the expiration of the **Waiting Period**, caused by natural causes;

3.1.2. Payment of Sum **Insured** as specified in the Policy in the event of the **Insured's death** caused by **Personal Accident** occurring during the **Period of Insurance**.

3.2. **In case of critical illness insurance:**

3.2.1. Payment of 10% of the Sum **Insured** as specified in the Policy upon **confirmation of diagnosis** of malignant tumor at pre-invasive stage, provided that the Primary Diagnosis was made after the expiration of the **Waiting Period**. In case of any other critical illness, payment of 100% of Current Sum **Insured** upon **confirmation of diagnosis** of a covered Critical Illness/a covered intervention was undergone, provided the Preliminary Diagnosis was made/necessity of the intervention was determined after the expiration of the **Waiting Period** and the **Insured** is alive after the expiration of the **Survival Period**;

Additionally, diagnostic tests shall not be started prior to the conclusion of the **Insurance Policy** or prior to the expiration of **Waiting Period**.

3.2.2. Arrangement of medical services in accordance with the Appendix #1;

3.2.3. **Definitions of Critical Illness Insurance covers:**

3.2.3.1. **Malignant invasive tumor –** The confirmed diagnosis of a malignant tumor, which is verified by histopathological report, invaded into a healthy tissue and is classified as malignant cancer according to the Eighth Edition of the AJCC-TNM classification (American Joint Committee on Cancer, AJCC Cancer Staging manual). Malignant tumors also include malignant lymphoma and malignant bone marrow disorders, including leukemia. If such diagnosis is made and confirmed during the **Period of Insurance** and after the expiration of the **Waiting Period**, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated/started before the expiry of the **Waiting Period**;

3.2.3.2. **The following malignant tumors on invasive stage are excluded:**

- Carcinoma in situ (CIS), tumor in situ (TIS), non-invasive cancer (tumor that has not invaded into a healthy tissue), dysplasia, benign tumors, cysts and all pre-malignant conditions;
- Malignant prostate tumors classified with a Gleason score less than 7 or staged less than T2bN0M0 or staged less than pT2N0M0 after full removal of the prostate (radical prostatectomy);
- Malignant thyroid tumors confined to the thyroid gland and/or regional lymph nodes;
- Urothelial tumors staged less than T1bN0M0;
- Gastrointestinal stromal tumors classified less than prognostic stage II according to the AJCC (Eighth Edition);
- Neuroendocrine tumors classified less than prognostic stage II according to the AJCC (Eight Edition);
- Basal cell and squamous cell carcinomas of the skin, and cutaneous lymphomas, sarcomas and dermatofibrosarcoma protuberans confined to the skin (for all, skin is defined as one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin);
- Malignant tumor diagnosed based on tumor cells and/or tumor-associated molecules found in blood, saliva, faeces, urine or any other bodily fluid, provided there is no further definitive and clinically verifiable evidence.

3.2.3.3. **Tumor at pre-invasive stage (carcinoma in situ) -** focal, localized growth of carcinomatous cells that is confined to the tissue where it first developed, without invasion into surrounding healthy tissue or other parts of the body. Pre-invasive and early stage malignant tumors of prostate or thyroid gland must always be positively diagnosed upon the basis of microscopic examination of fixed tissue (histopathological report). Pre-invasive cancers covered by this Terms and Conditions are limited to the following:

- Primary pre-invasive malignant tumors (carcinoma in situ) according to AJCC classification (American Joint Committee on Cancer, Eighth Edition TNM

Classification) except for malignant tumors of the skin other than melanoma in situ;

- If such diagnosis is made and confirmed during the **Period of Insurance** and after the expiration of the **Waiting Period**, the **Insurer** shall pay 10% of the Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated/started before the expiry of the **Waiting Period**;
- Prostate tumors classified with a Gleason score less than 7 or and staged less than T2bN0M0 or staged less than pT2N0M0 after full removal of the prostate (radical prostatectomy);
- If such diagnosis is made and confirmed during the **Period of Insurance** and after the expiration of the **Waiting Period**, the **Insurer** shall pay 10% of the Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**;
- Malignant thyroid tumors confined to the thyroid gland and/or regional lymph nodes(diagnosis must be confirmed according to the Eighth Edition of the AJCC-TNM classification);
- If such diagnosis is made and confirmed during the **Period of Insurance** and after the expiration of the **Waiting Period**, the **Insurer** shall pay 10% of the Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**.

In case the **Insurer** pays 10% of the Sum **Insured** under the aforementioned coverage, **Insurance Policy** shall remain in force until the Sum **Insured** is exhausted and/or the expiry of the Insurance Period.

3.2.3.4. **The following malignant tumors on pre-invasive stage are excluded from cover:**

- Dysplasia other than high grade Dysplasia being considered carcinoma in-situ;
- Any pre-malignant condition;
- Any malignant tumor of the skin except for melanoma in situ;
- Malignant tumor diagnosed based on tumor cells and/or tumor-associated molecules or markers found in blood, saliva, feces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence.

3.2.3.5. **Benign brain tumor, which requires surgery or results in permanent neurological deficit** - non-malignant brain tumor diagnosed by a neurologist or neurosurgeon and confirmed by relevant imaging tests (CT or MRI). Non-malignant brain tumors include intracranial tumors, tumors of meninges or intracranial tumors of cranial nerves, that cause damage to the brain. Such tumors shall require neurosurgical excision and/or radiotherapy, or if inoperable and incurable with radiotherapy, shall be causing permanent neurological deficit which continues for at least 3 (three) calendar months. In case of such intervention/diagnosing and/or confirmed permanent neurological deficit, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period** and the **Insured** is alive after the expiration of the **Survival Period**.

Epileptic seizures are not considered as a permanent neurological deficit;

3.2.3.6. **Following benign brain tumors are excluded from cover:**

- Cyst;
- Granuloma;
- Vascular malformation;
- Haematoma;
- Abscess;
- Spine tumors;
- Pituitary gland tumors, with tumor size of less than 10 mm.

3.2.3.7. **Myocardial Infarction (Heart Attack)** - final diagnosis of acute myocardial infarction: **death** of portion of heart muscle caused by obstruction of blood supply, which is confirmed by the typical rise and/or fall in cardiac biomarkers (Troponin I, Troponin T or CK-MB) to the level considered diagnostic of Acute Myocardial Infarction, plus at least 2 (two) of the following:

- Acute cardiac symptoms and signs consistent with Heart Attack;
- New ECG changes characteristic of an Acute Myocardial Infarction;
- Imaging evidence of new loss of viable myocardium or regional wall motion abnormality.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period** and the **Insured** is alive after the expiration of the **Survival Period**;

3.2.3.8. **Coronary Artery Bypass Surgery** – the undergoing of the surgery requiring median sternotomy to correct the narrowing of, or blockade to one or more coronary arteries by means of by-pass graft. The procedure must be considered necessary by a consultant cardiologist.

In case of such intervention, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period** and the **Insured** is alive after the expiration of the **Survival Period**;

3.2.3.9. **Stroke resulting in permanent/irreversible neurological deficit - death** of brain tissue resulting from inadequate blood supply or hemorrhage causing all the following:

- Abrupt onset of new neurological symptoms consistent with a stroke;
- New objective neurological deficit identified via clinical examination and which continues uninterrupted for at least ninety (90) days after the stroke is diagnosed;
- New changes identified on CT scan or MRI, which are consistent with the clinical diagnosis.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period** and the **Insured** is alive after the expiration of the **Survival Period**;

3.2.3.10. **The following is excluded from the Stroke definition:**

- Transient ischemic attack (TIA);

- Traumatic injury to brain tissue or blood vessels;
- Secondary haemorrhage into a pre-existing cerebral lesion;
- Any abnormality seen on brain or other scans without clearly related clinical symptoms and neurological signs;
- Death of tissue of the optic nerve or retina.

3.2.3.11. Paralysis - total loss of function of two or more limbs due to injury or disease, where such functional loss persists continuously for 3 (three) months and is evaluated as permanent by a neurologist. In case of such diagnosis is made and confirmed, the Insurer shall pay 100% of the Current Sum Insured to the Beneficiary provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the Waiting Period;

3.2.3.12. Blindness - total irreversible loss of sight in both eyes as a result of illness or accident, which cannot be corrected by surgery and shall be certified by an ophthalmologist. In case of such diagnosis is made and confirmed, the Insurer shall pay 100% of the Current Sum Insured to the Beneficiary provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the Waiting Period;

3.2.3.13. Kidney Failure – End stage (V) kidney disease (Kidney failure) for which regular dialysis is necessary. In case of such diagnosis is made and confirmed, the Insurer shall pay 100% of the Current Sum Insured to the Beneficiary provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the Waiting Period. Pre-existing kidney failure of any stage is excluded;

3.2.3.14. Major Organ Transplant – The actual undergoing of a transplant of any of the below organ as a recipient or the inclusion on an official organ transplant waiting list for any of the below organs:

- One of the following whole human organs: Heart, lung, liver, kidney, pancreas, or
- Human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation.

The transplant must be medically necessary and based on objective confirmation of organ failure.

In case of such diagnosis is made and confirmed, the Insurer shall pay 100% of the Current Sum Insured to the Beneficiary provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the Waiting Period.

Other than the above stem cell transplants are excluded;

3.2.3.15. Aorta Surgery – The undergoing of surgery for disease of the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term “aorta” includes the thoracic and abdominal aorta but not its branches. In case of such diagnosis is made and confirmed, the Insurer shall pay 100% of the Current Sum Insured to the Beneficiary provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the Waiting Period. Minimally invasive stent grafting is excluded;

3.2.3.16. Heart Valve Surgery – Open or endoscopic heart valve surgery, performed to replace or repair one or more heart valves. Included are also minimally invasive procedures and transcatheter aortic valve replacement. The procedure must be performed after a recommendation by a consultant cardiologist. In case of such diagnosis is made and

confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**;

3.2.3.17. **Multiple Sclerosis (MS)** – an inflammatory and demyelinating disease of the brain and/or spinal cord which causes neurological symptoms and signs. The diagnosis of MS must be confirmed by a consultant neurologist according to the International Panel Criteria (Revised McDonald Criteria). Possible MS and isolated neurological syndromes suggestive but not diagnostic of MS are excluded;

3.2.3.18. **End Stage Liver Disease** – chronic end-stage liver failure that causes at least two of the following lasting for at least 90 days:

a) Permanent Jaundice;

b) Uncontrollable ascites;

c) Hepatic encephalopathy;

d) Esophageal or gastric varices.

The diagnosis must be confirmed by a consultant hepatologist or gastroenterologist based on clinical medical evidence. Liver disease secondary to alcohol or drug abuse is excluded. In addition, pre-existing liver failure (diagnosed prior to the expiry of **Waiting Period** or prior to the conclusion of the **Contract of Insurance**) of any stage is excluded.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**;

3.2.3.19. **Apallic Syndrome (vegetative state)** – A state of unconsciousness with no reaction or response to external stimuli or internal needs, persisting continuously with the use of life support systems, for a period of at least ninety-six (96) hours. Permanent neurological deficit, as certified by a consultant neurologist, must be present for the first time in the life of the **insured** as well as in the Insurance Period.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**.

The following are excluded from the cover:

- Coma caused by the use of alcohol, narcotics or drugs without doctor's prescription;
- Coma caused / maintained for the purpose of treatment.

3.2.3.20. **Bacterial encephalitis or meningitis resulting in permanent neurological deficit** – Acute infection of central nervous system resulting in permanent neurological deficit persisting continuously for at least 90 (ninety) days as certified by a consultant neurologist. Confirmation of bacterial infection in cerebral fluid by lumbar punctum is required.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**;

3.2.3.21. **Irreversible Deafness** – Total, irreversible bilateral loss of hearing for all sounds as a result of sickness or accidental injury. Medical evidence to be supplied by an appropriate (Ear, Nose and Throat) specialist and to include audiometric and sound-threshold (TEN) test. The deafness must not be able to be corrected by any medical procedure (including hearing aids or cochlear implant) and examinations have not been initiated before the expiry of the **Waiting Period**.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**.

Deafness correctable by any medical procedure (including hearing aids or cochlear implant) is excluded;

3.2.3.22. **Viral Encephalitis resulting in permanent neurological deficit** – severe inflammation of brain substance (cerebral hemisphere, brainstem, or cerebellum) resulting in permanent neurological deficit. This diagnosis must be certified by a consultant neurologist and the permanent neurological deficit must be documented for at least 90 days.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**.

Encephalitis caused by HIV infection is excluded;

3.2.3.23. **Loss of Speech** – Total and irrecoverable loss of the ability to speak caused by brain damage/disease which must be established for a continuous period of 6 (six) months at least. Medical evidence is to be supplied by an appropriate consultant medical specialist and to confirm injury or disease to the vocal chords or damage of brain center for speech resulting from brain injury, tumor or disease.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**. All psychiatric or self-harm related causes are excluded;

3.2.3.24. **Major Burns** – 3rd degree burns covering at least 20% of the body surface.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**;

3.2.3.25. **Poliomyelitis** – the occurrence of poliomyelitis where the following conditions are met:

- Poliovirus identified as a cause;
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least continuous 90 (ninety) days.

3.2.3.26. **Parkinson's Disease resulting in inability to perform activities of daily living (ADL's)** – unequivocal diagnose of Parkinson's Disease by a consulting neurologist, based on definitive signs of progressive and permanent neurological impairment, where the **insured** person has permanent inability to perform at least three out of following Activities of Daily Living (ADL's), in spite of being on optimal medication.

The list of Activities of Daily Living:

- Dressing – the ability to put on and take off clothing without any assistance;

- Transfer – the ability to get in and out of bed or a chair without any assistance;
- Mobility – the ability to move from room to room without any physical assistance;
- Continence – the ability to control bowel and bladder function to maintain personal hygiene;
- Feeding – the ability to get food from a plate into the mouth without assistance;
- Bathing – the ability to bathe and shower without assistance.

Parkinson's disease secondary to drug or alcohol abuse is not covered.

In case of such diagnosis is made and confirmed, the **Insurer** shall pay 100% of the Current Sum **Insured** to the **Beneficiary** provided that no health issues related to the disease have arisen and examinations have not been initiated before the expiry of the **Waiting Period**.

3.3. **Additional exclusions clause applicable to the insured children:**

Terms and Conditions of this insurance establish additional exclusions for persons insured as children - Following pre-existing conditions are not covered:

- Health conditions that transpired at birth or were diagnosed before the age of one (1);
- **Insured** had knowledge of the health condition prior to the conclusion of the **Contract of Insurance**;
- Health conditions for which **Insured** sought medical advice prior to the conclusion of the **Contract of Insurance**;
- Health conditions transpired before the conclusion of the **Contract of Insurance**, for which prudent parent would have sought medical advice.

4. EXCLUSIONS

4.1. **Subject to present Terms and Conditions, in case of death of the Insured, or the occurrence of a risk covered by Critical Illness insurance the Insurer is free from any liability to pay the claim, if the Insured Event is directly or indirectly caused by the following:**

4.1.1. Use of narcotics, toxic, psychotropic substances or alcohol and any complications thereof; **Insured** was under the influence of alcohol and/or narcotics, and/or toxic, and/or psychotropic substances at the time of **death**, unless narcotic and/or psychotropic substances were prescribed by a certified physician in line with existing medical evidence;

4.1.2. **Death** of the **Insured** caused by AIDS, HIV, or any type of hepatitis (except hepatitis A), cirrhosis of the liver, liver cancer or any complications thereof;

4.1.3. Suicide, self-harm or attempted suicide; willful negligence of danger (unless **Insured's** actions were directed at saving a life);

4.1.4. Involvement of the **Insured** in illegal activities under the legislation of Georgia (or any other country where **death**/accident has occurred);

4.1.5. Participation in war (declared or undeclared), civil war, uprising, revolution, strike, military coup;

4.1.6. Deliberate action of the heir of the **Insured** or a person directly or indirectly interested in the **indemnification** of insurance benefits specified in this insurance;

4.1.7. Any act of terrorism. An act of terrorism means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) for political, religious, ideological or ethnic purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes;

4.1.8. Mental health disorders of the **Insured**, except in cases where **Insured** becomes ill after the Policy inception date and the expiry of the **Waiting Period**; (except an event provided for in paragraph 3.2.3.23);

4.1.9. **Insured's** participation in high-risk activities: combat sports, scuba diving, hunting, rock-climbing, mountaineering, rafting, driving a motorboat, catamaran, riding ATV, parachuting, delta- and paragliding, skysurfing, windsurfing, parkour, extreme biking (mountain biking, dirt jumping), auto and motor sports, racing, horse racing, caving, ski jumping, snowmobiling, freestyle skateboarding, heli skiing, Ski-cross, skiing/snowboarding off-piste; extreme and professional sports, aviation and sports related thereto; **death**/ disability/bodily injury of the **Insured** caused by bets, aerobatic tricks, breaking or trying to break records;

4.1.10. Driving a vehicle and/or any other mechanical vehicle without respective driver's license and/or under the influence of alcohol, narcotic, toxic or psychotropic substances;

4.1.11. Service or participation of the **Insured** in the police, navy, army, air force or military operations/trainings;

4.1.12. **Insured's** professional activities, such as mining, underground quarrying, works related to military ammunition and explosives, petroleum products, hazardous chemicals, high-voltage cables, oil and gas well drilling/exploration or other increased risk activities;

4.1.13. Influence of nuclear power (nuclear reactions, radiation, pollution) ,or any damage or disease which is directly or indirectly caused or resulted from ionizing radiation or radioactive contamination caused by nuclear fuel or nuclear fuel explosion;

4.1.14. Aviation risks, except in cases where the **Insured** is a passenger on a regular or charter flight;

4.1.15. Unreasonable denial of medical treatment; also, deterioration of health as a result of treatment undertaken in an unlicensed medical facility, or self-treatment by the **Insured**;

4.1.16. Any case where the diagnosis/condition and/or circumstances of **death** event has not been established and any case if according to Medical Certificate of **Death** – form N106/S-4 the "Diseases and/or conditions causing **death**" are: "Other unspecified and imprecisely determined causes of **death**" and/or the "Cause of **death**" column indicates: "Undetermined". In the event of the **death** of the **Insured** outside the borders of Georgia, the medical certificate of **death** issued by the official agency of the relevant country,

stating conditions similar to the above form N106/s-4, or if the cause of **death** is not recorded in the same or similar document.

Recognition of the **Insured** as a missing person shall not be considered an **Insured Event**;

4.1.17. Withholding or presenting fraudulent information/documentation related to the **Insured's** health, and/or profession/occupation, or any other information at any point in the contractual relationship – contract formation, during the **Period of Insurance** and/or after the **Insured Event**;

4.1.18. If the **Insured** changes his/her profession or occupation and fails to notify the **Insurer**, provided such change may have an impact on the **Insured Event**.

4.2. **Under present Terms and Conditions, Indemnification shall not be paid, if:**

4.2.1. Documents requested by the **Insurer** to assess the claim have not been submitted in full;

4.2.2. Information submitted to the **Insurer** during the Policy purchase, including information provided in the declaration/questionnaire, is incorrect, inaccurate and/or incomplete;

4.2.3. Upon occurrence of the **Insured Event, Insurance Premium** was not paid in accordance with the requirements of the present Terms and Conditions;

4.2.4. **Insured Event** related documentation/information submitted to the **Insurer** by the **Insured** and/or the **Beneficiary** does not correspond to factual circumstances and/or is false;

4.2.5. **Death** by natural causes occurred during the **Waiting Period**;

4.2.6. **Insureds** who fail to meet insurance eligibility criteria under present Terms and Conditions;

4.2.7. Events occurring during the **Insured's** stay in a penitentiary facility.

5. BASIS AND TERMS OF INDEMNIFICATION

5.1. The **Beneficiary** shall notify the **Insurer** (hotline number +995 32 2 42 22 22 or e-mail: life@tbcinsurance.ge) of the **Insured Event** no later than 1 (one) month after the event and no later than 1 (one month) from the notification (except for those documents that require more time to be issued according to the local legislation - the deadline for providing such documents to the **Insurer** shall not exceed 1 (one) month after the expiration of the deadline provided for by law) submit the following documents:

5.1.1. **Upon occurrence of any Insured Event:**

- Claims Form (application);
- A copy of the identity document of the **Insured**;
- **Insurance Policy**;
- **Beneficiary(ies)** identity document(s);
- **Beneficiary(ies)** bank account details;

5.1.2. **In case of death of the Insured:**

- Original or notarized copy of the **Death** Certificate;
- Medical Certificate stating the cause of **death** (Form 106 / S-4);
- Medical Certificate stating the diagnosis (medical documentation Form No. IV-100/A);
- In case of **death** caused by **Personal Accident**, a report issued and signed by the relevant law enforcement authorities;
- Notarized Certificate of Inheritance (if necessary);
- If necessary, copies of ID cards of family members (spouse, children, parents, siblings), as well as copies of Birth Certificates of family members (spouse, children, parents, siblings) and a copy of the Marriage Certificate of the **Insured**;
- If cause of **death** cannot be established based on the documents provided, the **Insurer** shall have the right to request a forensic medical examination report.

5.1.3. **In case of a critical illness diagnosis:**

- Documentation confirming the diagnosis (medical form iv-100/a, medical history, results of histomorphological study and any other examination and imaging test results, if required);
- Final diagnosis of Critical Illness confirmed by the **Attending Physician** must meet the definition and criteria of the illness as set forth in this Terms and Conditions.

5.2. Depending on a specific case, in order to accurately determine the circumstances of the **Insured Event**, the **Insurer** reserves the right to request additional documents, different from those listed above and/or additional diagnostic tests which the **insured** must carry out within 1 (one) month from the **Insurer's** request, unless the obtaining of specific document(s)/conducting diagnostic tests requires a longer period.

5.3. The **Insurer** shall, within 15 (fifteen) business days after receipt of all the requested documents, review the case and either pay or reject the claim.

5.4. Insurance **Indemnification** paid by the **Insurer** to the **Beneficiary(ies)** shall be within the limits of Sum **Insured** /Current Sum **Insured**.

5.5. If **Insured's** legal heir(s) is named **Beneficiary(s)**, Insurance **Indemnification** shall be paid to person(s) specified in the inheritance certificate, in the manner and/or percentage ratio specified in the inheritance certificate.

5.6. If **Insured** is covered under the **Insurer's** other voluntary term life insurance product(s), total amount of **indemnification** under this insurance shall not exceed the amount of Sum **Insured** specified on this Policy, regardless of number of other insurance policies and their sums **insured**/limits.

5.7. In respect of Critical Illness Insurance, if the **Insured** is incapacitated, **indemnification** shall be paid to his/her legal representative/guardian. If the **Insured Event** occurred during the **Period of Insurance** and was declared to the **Insurer** and the decision to pay **Indemnification** was made by the **Insurer** whilst the **Insured** was alive, but insurance payout was not issued prior to his/her **death**, **indemnification** shall be paid to the **Insured's** legal heir(s).

5.8. If covered critical illness is diagnosed and confirmed during the policy period and provided Critical Illness Insurance is purchased together with the Life Insurance under a single policy, **Insurer** shall pay the claim under Critical Illness section of the Policy, whilst Life Insurance cover/section of the policy shall remain in force.

6. CONTRACT OF INSURANCE AND ITS ENTRY INTO FORCE

6.1. **Contract of Insurance** shall come into force at 24:00 hours of the Policy inception date and shall continue in full force and effect until 24:00 hours of the policy expiry date as specified in the Policy.

6.2. Unless **Policyholder** pays first or single premium payment in accordance with the premium payment schedule specified in the Policy, the **Insurer** is free from any liability to pay the claim.

7. INSURANCE PREMIUM AND ITS PAYMENT

7.1. **Insurance Premium** is payable in GEL.

7.2. Amount of the **Insurance Premium** and its payment schedule are specified in the Policy.

7.3. If **Policyholder** fails to pay single (in case of lump sum payment) or first premium installment (in case of multiple payments) in full before the end of the month in which the Policy has incepted, the Policy shall be voided from the date of inception, without any further notice to the Policyholder.

7.4. In case of multiple installments, if **Policyholder** fails to pay premium installment (i.e. any installment except the first) in accordance with the premium payment schedule, the **Policyholder** shall have additional two weeks from the due date to make a payment. If the premium is not paid within these 14 (fourteen) days, losses occurring after the expiry of this 14 (fourteen)-day period shall not be paid. Upon the expiry of 30 (thirty) calendar days from the due date (at 24:00 hours of the 30th day), the **Contract of Insurance**/Policy shall be unilaterally terminated by the **Insurer**.

7.5. In case of multiple installments, if the **Insurer** terminates the Contract due to non-payment of premium by the **Policyholder** within 30-day period, the **Policyholder** shall pay the full amount of outstanding earned premium at the date of termination.

7.6. If case of early termination of the **Contract of Insurance** by the **Policyholder** and provided no claim has been paid or medical service provided by the **Insurer** before the termination, **Policyholder** shall pay the amount of outstanding earned premium at the date of termination and an early termination fee in the amount of one-month premium.

7.7. In case the **Insurer** has paid the claim or provided medical service during the Policy period, the **Policyholder** shall pay the full amount of the **Insurance Premium** for the current Insurance Period (Unearned Premium). The **Insurer** shall have the right to deduct Unearned Premium for the current Insurance Period from the amount of claims payment.

7.8. If the Contract is terminated due to the **death** of the **Insured**, total unpaid premium under the Contract shall be deducted from the claims amount.

8. INSURANCE CONTRACT / COVERAGE TERMINATION

8.1. The **Contract of Insurance** shall be terminated:

8.1.1. At any time, on the initiative of the Policyholder, based on 5 (five) calendar days preliminary written notice to the **Insurer;**

8.1.2. At any time, on the initiative of the **Insurer**, based on 14 (fourteen) calendar days preliminary written notice to the Policyholder;

8.1.3. On the initiative of the **Insurer**, without prior notice to the Policyholder, if obligations undertaken by the **Insurer** under the **Contract of Insurance** are fully fulfilled/total Sum **Insured** under the **Contract of Insurance** is exhausted.

8.2. The **Contract of Insurance** shall also be terminated:

8.2.1. Upon expiry of the Insurance Period under the Policy;

8.2.2. Upon **death** of the **Insured**;

8.2.3. Based on preliminary written agreement of the **Insurer** and the Policyholder;

8.2.4. If the **Insurer** terminates its activities in accordance with the current legislation;

8.2.5. If the **Policyholder** fails to fully pay outstanding premium within 30 (thirty) calendar days after receiving payment notice from the **Insurer**;

8.2.6. In other cases, as provided for by the legislation of Georgia;

8.2.7. Critical Illness Insurance cover in respect of all **Insureds** terminates on payment of 100% of Sum **Insured** to the Principal **Insured** and is not subject to renewal;

8.2.8. If 100% of Sum **Insured** is paid to the **Insured** Child/Children, the Policy continues to be in force but the insurance cover in respect of that particular child/children ceases and is not subject to renewal.

9. NOTICES AND COMMUNICATION

9.1. For the purposes of this insurance, the parties agree that the address and/or mobile phone number specified in the Policy may be used for communication and notices sent by the **Insurer**. A letter sent to this address or a message sent to this mobile phone number (including Short Message Service) shall be a formal written notice by the **Insurer**. If the notice is sent to the phone number, the date of sending shall be deemed to be the date of its receipt by the addressee.

9.2. The **Insurer** shall send a notice to the **Policyholder** using actual address indicated in the Policy or, in case of address change, provided such change was undertaken in accordance with the requirements of present Terms and Conditions, to the last address notified to the **Insurer**. Any notice/correspondence sent to such address shall be deemed to have been received by the Policyholder, even if the addressee no longer resides at this address or the address is indicated incorrectly/incompletely.

10. DISPUTE RESOLUTION

10.1. The parties shall attempt to resolve any dispute arising out of or relating to present Insurance Terms and Conditions through negotiations. In case parties fail to reach an agreement, the dispute shall be resolved by the Georgian court in accordance with the legislation of Georgia.

10.2. In case of any discrepancy between Georgian and translated versions of present Terms and Conditions, Georgian version shall prevail.

11. CONFIDENTIALITY

11.1. Any information exchanged by the parties (whether verbally or in writing) shall be deemed confidential and shall not be disclosed to any the third party(ies) without preliminary consent of the other party, except where such disclosure is required by the current Georgian legislation or present Terms and Conditions.

12. PERSONAL DATA PROCESSING

12.1. The **Policyholder** authorizes the **Insurer** to process personal data received in the course of insurance (including special category data) for the purpose of: a) providing insurance services; b) protecting **Insurer's** interests; c) performing contractual and/or legal obligations of the **Insurer**; and d) claims settlement. For the same purposes, the **Insurer** is also authorized to request **Policyholder's/Beneficiary's** personal information and/or any other necessary documents from any private or public company, including subsidiaries/affiliated companies of JSC "TBC Insurance", MIA Service Agency and State Services Development Agency.

12.2. The **Policyholder** authorizes the **Insurer** to process personal data for direct marketing purposes, namely, to offer new insurance products and services. The data subject is entitled to request at any time that the **Insurer** stops using his/her data for direct marketing purposes in the same form as the direct marketing is conducted - in writing or via telecommunications.

12.3. The **Policyholder** authorizes the **Insurer** to process **Policyholder's/Beneficiary's** personal information and to make it available to its partner companies, for the purposes of offering insurance services and/or quality control and/or insurance related studies.

12.4. The **Policyholder** authorizes the **Insurer** to process insurance related information (**period of insurance**, policy status, **insurance premium**, etc.) to allow **Insurer** to comply with the relevant contractual or legal obligations, and to make it available to **Insurer's** agent(s) and/or partner companies who need it to properly perform their duties.

APPENDIX #1 - MEDICAL SECOND OPINION AND ARRANGEMENT OF MEDICAL SERVICES ABROAD

This Appendix forms an integral part of the Individual Term Life and Critical Illness Insurance Terms and Conditions.

DEFINITION OF TERMS

ATTENDING PHYSICIAN	A physician with relevant medical education, who holds state certificate confirming his/her right to engage in medical practice, and gives advice to the Insured, prescribes and performs tests and by whom the initial diagnosis is made.
BUSINESS DAY	Official business days in Georgia and the USA.
WORKING HOURS	Official business hours in Georgia.
DIAGNOSIS	Diagnosis made by the Attending Physician following Insured's examination and testing. Diagnosis shall include the name of the disease or the suspected pathology.
MEDICAL RECORDS	Documents on health state of the Insured, issued by the Attending Physician and/or other representative of the healthcare/medical institution in compliance with the state standards. The documentation should include final diagnosis/diagnoses, results of physical, laboratory, instrumental and other examinations and recommendations for treatment.
PHYSICIAN	A physician who holds a license/certificate confirming his/her right to engage in medical practice in the United States of America or other country.
"MEDIGUIDE INTERNATIONAL" (MEDIGUIDE)	Insurer's partner organization responsible for arranging Medical Second Opinion and medical services abroad, that are financed by the Insurer and are compliant with the provisions of present Terms and Conditions.
MEDICAL CASE SUBJECT TO REVIEW	Illness or deterioration of health condition, which allows the Insured to request the review of his/her medical records for the purposes of obtaining Medical Second Opinion. Any medical case shall fall within the scope of the review, except for the following: o No diagnosis has yet been made - the Insured shall have formal diagnosis to be eligible for Medical Second Opinion, otherwise the case shall not be reviewed;

- The Insured has not consulted a physician during the last 12 months - data for the last one (1) year is necessary to evaluate the case;
- Acute or life-threatening health condition – a condition that requires immediate medical intervention and cannot be delayed for the purposes of obtaining Medical Second Opinion;
- Case review requires physical examination by the physician.

MEDICAL SECOND OPINION PROVIDED BY MEDIGUIDE

Written report by a physician working at the World Leading Medical Center, which includes diagnosis and treatment recommendations and which is provided to the Insured and his/her Attending Physician. The report shall be drawn up in the language of the World Leading Medical Center and translated into Georgian.

WORLD LEADING MEDICAL CENTER

Medical facility recognized by the medical community as one of the leading medical clinics providing specialized medical care.

ASSISTANCE

A specialized company providing 24-hour telephone medical advice, medical records and other services related to organization of Medical Second Opinion and/or medical services abroad. Assistance operators speak Georgian.

1. SERVICE PROCESS AND COSTS COVERED

1.1 Service Process and Costs Covered:

1.1.1. The **Insured** shall call the **Insurer's** hotline at +995 32 242 22 22 to seek Medical Second Opinion. After identification of the **Insured**, the **Insurer** shall redirect the **Insured** to MediGuide hotline (hereinafter referred to as the "Assistance") to report the diagnosis made by his/her **Attending Physician**, and in respect of which the **Insured** seeks Medical Second Opinion;

1.1.2. MediGuide shall, within 3 (three) business days from the date of the first call by the **Insured**, considering his/her diagnosis, select three best medical centers in the respective field and forward the list to the **Insured**. The **Insured** shall, with the help of his/her Physician, choose one medical center in which he/she wishes to seek Medical Second Opinion;

1.1.3. By signing the Consent Form provided by MediGuide, the **Insured** agrees and authorizes MediGuide to request and collect **Insured's medical records** pertaining to the health condition in question. The Consent Form shall be sent to the **Insured** within 12 (twelve) working hours after the first call to the Assistance;

1.1.4. Once the **Insured** chooses the clinic and signs the Consent Form, MediGuide shall, with the help of the **Insured's Attending Physician**, obtain all the necessary **medical records** to be transferred to the clinic;

1.1.5. The **Insured** and his/her **Attending Physician** will, within 10 (ten) working days after the receipt of the **Insured's medical records** by the clinic, receive an independent written opinion from the clinic on the **Insured's** initial diagnosis, along with recommendations for treatment, in compliance with all laws and regulations on medical confidentiality. These recommendations shall include optimal treatment and care options based on the latest established medical practices and international standards;

1.1.6. If a medical institution and/or medical personnel refuse to provide **medical records** to MediGuide Assistance, obligation to obtain these records shall sit with the **Insured**. MediGuide shall bear no responsibility for failure to provide Medical Second Opinion, if the **Attending Physician**, relevant medical facility or facility personnel fail to provide MediGuide with copies of **medical records** and medical examination results;

1.1.7. At the request of the **Insured**, MediGuide shall communicate using telephone, fax, e-mail, mail, FedEx or DHL;

1.1.8. The cost of following services shall be covered by MediGuide International:

- Search for the world's leading specialized medical center, which shall provide Medical Second Opinion within the time limits specified by this Terms and Conditions;
- Remuneration of the **Attending Physician** or medical institution for obtaining **Insured's medical records**, making copies and compiling them into a single file;
- Translation of **medical records** into the language in which the World Leading Center conducts its operations;
- Sending **medical records** file to the World Leading Medical Center and getting the file back via express mail after the review;

- Electronic transmission of medical files and/or images, in compliance with the rules and laws on personal data protection;
- Teleconferences with physicians;
- Review of **medical records** by the World Leading Medical Center, preparation of Medical Second Opinion and treatment recommendations;
- Translation of the Medical Second Opinion into Georgian language;
- Assistance services.

1.1.9. Neither MediGuide nor the **Insurer** shall be liable for non-performance or improper performance of services under this Contract, if it is caused by or results from a voltage drop, disruption or shutdown of electricity and/or telecommunications and/or Internet, state restrictions, flood, strike, terrorist act, earthquake, explosion, embargo, shortage of personnel or material resources, traffic disruption or any other event beyond the control of "MediGuide International" and/or the **Insurer**;

1.1.10. Coordination of emergency medical service is not provided under this Contract;

1.1.11. Medical Second Opinion for the same diagnosis shall be prepared only once during the **Period of Insurance**, unless health condition of the **Insured**, despite strict adherence to treatment recommendations set out in the first Medical Second Opinion, has not improved within the prescribed period, whilst such improvement was expected under the treatment plan. In such a case, MediGuide International shall provide a repeated Medical Second Opinion considering new circumstances.

2. ARRANGEMENT OF MEDICAL SERVICES ABROAD

2.1. Under present Terms and Conditions, MediGuide shall organize treatment recommended by the Medical Second Opinion at a medical institution outside of Georgia selected by the **Insured**, together with travel and hotel accommodation associated with the treatment.

2.2. If, during review of the **Insured's medical records**, specialists of the World Leading Medical Center deem it necessary to perform additional examinations, MediGuide International shall organize such examinations abroad at the clinic selected by the **Insured**.

2.3. Medical services abroad shall be organized only after obtaining Medical Second Opinion.

2.4. Neither cost of medical services (examinations, consultations and treatment), nor travel or accommodation expenses shall be reimbursed under this **Contract of Insurance**.

2.5. **Service Process:**

2.5.1. The **Insured** shall call the **Insurer** hotline at +995 32 242 22 22 to seek Medical Services Abroad and shall specify the region/country where he/she wishes to undergo treatment based on the recommendations specified in the Medical Second Opinion;

2.5.2. After obtaining written consent from the **Insured**, MediGuide shall deliver a copy of the Medical Second Opinion together with the copy of the Consent Form to its Partner (hereinafter referred to as the "MediGuide Partner"), which operates in the region selected by the **Insured** and provide **Insured's** contact details;

2.5.3. MediGuide Partner shall contact the **Insured**, offer him/her a list of clinics, provide prices for medical services and, if requested, travel and hotel accommodation rates. Preliminary

estimate of medical services shall not include costs associated with the treatment of expected/unexpected complications. The Insured shall choose the clinic where he/she wishes to receive medical care;

2.5.4. MediGuide Partner shall enter into service agreement with the Insured, whereby the Insured shall transfer the amount specified in the above agreement, which is the estimated cost or a part thereof of medical services to be provided at a medical institution;

2.5.5. The MediGuide Partner shall provide the following services:

- Organization of outpatient visits to a medical institution and hospitalization therein;
- Ensuring compliance with tax requirements related to provision/receipt of medical services;
- Supervision of the treatment process at the request of the Insured in order to optimize medical services;
- Review of medicines prescribed upon discharge from a medical facility, which means checking whether prescribed medicines are registered and sold in Georgia and, if necessary, procurement of certain supplies to continue treatment in Georgia;
- Organization of arrival and return to Georgia, local transfers, accommodation of the Insured and/or his/her accompanying persons in a hotel near the clinic, medical evacuation;
- MediGuide Provider shall bear no responsibility for changes in prices for scheduled transfers, delays or cancellations of flights or other changes in the schedule;
- In the event of death of the Insured, organization of repatriation of the deceased to the International Airport of Georgia or local burial/cremation. MediGuide Provider shall bear no responsibility for providing this service in any particular timeframe.