TBC INSURANCE

Critical Illness Insurance Terms and Conditions

CII-02/21

CONTENTS

CRITICAL ILLNESS INSURANCE

MEDICAL SECOND OPINION AND MEDICAL SERVICES ABROAD

Insurance Covers

Important Information

Exclusions

CRITICAL ILLNESS 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 enters into a Contract of Insurance with the Insurer in accordance with present Terms and Conditions.
INSURED	Natural person under the age of 65, his/her child/children who are between one and 18 years of age and are noted on the Insurance Policy. Children under the age of 18 can only be insured under a parents' policy.
BENEFICIARY	Person entitled to receive insurance indemnification and/or insurance services upon occurrence of the Insured Event. For the purposes of this insurance, Primary Beneficiary is noted on the Insurance Policy. Primary Beneficiary is the Insured. If Primary Beneficiary dies, insurance indemnification shall be paid to the Contingent Beneficiary designated on the Policy. If no Contingent Beneficiary is designated on the Policy, indemnification shall be paid to the Insured's legal heir/heirs.
INSURANCE POLICY	Document certifying conclusion of the Contract of Insurance and stating details of the insurance cover.
INSURANCE PREMIUM	Cost of insurance to be paid by the Policyholder in the amount and form as indicated in the Insurance Policy.
SUM INSURED / LIMIT OF INDEMNITY	Maximum amount of indemnification to be paid by the Insurer to the Beneficiary designated on the Policy upon occurrence of the Insured Event during the Period of Insurance. Sum Insured is indicated in the Insurance Policy.
INDEMNIFICATION	Amount payable by the Insurer to the Beneficiary upon occurrence of the Insured Event, within the limits of Sum Insured/Limit/Sub-limit.
INSURED EVENT	Event(s) specified in the Contract of Insurance, which occurrs during the Period of Insurance and triggers Insurer's liability to indemnify the claim.
INSURANCE COVER	Events listed in the Policy, which could lead to an Insured Event.
TERRITORY OF COVER	Worldwide.
PERIOD OF INSURANCE	Period during which insurance cover is valid and Insured Events are subject to indemnification.
CONTINUOUS RENEWAL	Renewal of a policy on a next calendar day after its expiry/termination (at 24:00 hours of the expiry date).

ATTENDING PHYSICIAN	Duly certified and licensed physician who has diagnosed critical illness and who is in charge of treating the Insured. The Insured cannot be an Attending Physician.
DIAGNOSIS	Formal medical report produced by an Attending Physician in compliance with the state standards, indicating exact name of the critical illness, international code (ICD-10), form and stage.
MEDICAL RECORDS	Documents pertaining to health condition of the Insured, produced 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 and conclusions of physical, laboratory, instrumental and other examinations/tests and recommendations for treatment.
PRE-EXISTING CONDITION	Critical illness covered under present Terms and Conditions, which is diagnosed and/or clinical examination undertaken/started prior to the conclusion of the Contract of Insurance. In case of a pre-existing condition, the Insurer is free from any liability to indemnify the claim.

1. SUBJECT MATTER OF INSURANCE AND INSURANCE COVERS

1.1 **Present insurance envisages:**

- Payment of 10% of the Sum Insured as specified in the Insurance Policy to the Beneficiary upon diagnosis of pre-invasive cancer, provided the diagnosis was made after expiration of the Waiting Period. In case of any other critical illness, payment of 100% of the Sum Insured as specified in the Insurance Policy upon diagnosis of a Critical Illness, provided the diagnosis was made after the expiration of the Waiting Period and the Insured is alive after the expiration of the Survival Period. Survival Period shall only apply to Myocardial Infarction, Paralysis and Coronary Artery Bypass Surgery.

- Arrangement of medical services in accordance with the Attachment #1 thereof.

2. DEFINITION OF INSURANCE COVERS

2.1 **Malignant invasive tumor (cancer), clinical stages II, III, IV –** malignant tumor, which shall be verified by histopathological report and is characterized by uncontrolled growth and invasion into a healthy tissue. Cancer includes malignant lymphoma and malignant bone marrow disorders, including leukemia. If such diagnoses is made during Period of Insurance and after the expiration of the 90-day Waiting Period, the Insurer shall pay 100% of the Sum Insured to the Beneficiary.

2.1.1 **The following malignant tumors are excluded:**

- Carcinoma in situ, cancer in situ, non-invasive cancer (clinical stage 0), dysplasia and all pre-malignant conditions;
- Prostate cancer at pre-T2bN0M0 stages (clinical stages 0 and I);
- Papillary or follicular thyroid cancer at pre-T2N0M0 stages (clinical stages 0 and I);
- Basal cell and squamous cell carcinomas of the skin, and dermatofibrosarcoma protuberans;
- Cancer diagnosed on the basis of 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.

2.2 **Cancer at pre-invasive stage (carcinoma in situ, clinical stages 0 and I)** - focal, localized autonomous growth of carcinomatous cells confined to the tissue where it first developed without invasion into surrounding healthy tissue or other parts of the body. Diagnosis of non-invasive cancer must always be confirmed by microscopic examination (histopathological report) of the fixed tissue. Non-invasive cancers covered by this Terms and Conditions are limited to the following:

- All primary pre-invasive cancers (carcinoma in situ) according to AJCC classification (American Joint Committee on Cancer, Seventh Edition TNM Classification). If such diagnosis is made during the Period of Insurance and after the expiration of the 90-day Waiting Period, the Insurer shall pay 10% of the Sum Insured to the Beneficiary. Inurance Policy shall remain in force until such time as Sum Insured is exhausted and/or the expiry of the Insurance Period.

2.2.1 **The following pre-invasive cancers are excluded:**

- Dysplasia and any pre-malignant conditions;
- Any skin cancer except for melanoma in situ;
- Cancer diagnosed on the basis of tumor cells and/or tumor-associated molecules found in blood, saliva, feces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence.

2.3 **Benign brain tumor, which requirs surgery or may result in permanent neurological deficit -** non-ancerous brain tumor diagnosed by a neurologist or neurosurgeon and confirmed by relevant imaging tests (CT or MRI). Non-cancerous brain tumor includes intracranial tumors, tumors of meninges or intracranial tumors of cranial nerves, that cause damage to the brain. Such tumors shall require neurosurgical excision, or if inoperable, shall be causing permanent neurological deficit which continues for at least three months. In case of such diagnoses, the Insurer shall pay 100% of the Sum Insured the Beneficiary. Epileptic seizures are not considered permanent neurological deficit.

2.3.1 **Following benign brain tumors are excluded:**

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

2.4 **Myocardial Infarction (Heart Attack) -** final diagnosis of acute myocardial infarction: death 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) by at least one level above the 99th percentile of the upper reference limit and accompanied by one of the following:

- Acute cardiac symptoms and signs consistent with angina;
- Newly developed changes in ECG: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block;
- Newly developed death of healthy heart muscle or regional wall motion abnormality confirmed by imaging tests;
- Intracoronary thrombus identified by angiography.

2.4.1 **Other acute coronary syndromes including but not limited to unstable angina are excluded.**

2.5 **Coronary Artery Bypass Surgery –** In case of open heart coronary artery bypass graft surgery to treat a blockage or narrowing of one or more of the coronary arteries, the Insurer shall pay 100% of the Sum Insured to the Beneficiary.

Percutaneous coronary interventions such as angioplasty and all other intra-arterial, catheter based techniques or laser procedures are excluded.

2.6 **Stroke resulting in permanent/irreversible neurological deficit -** death of brain tissue resulting from inadequate blood supply or haemorrhage and causing:

- Abrupt onset of new neurological symptoms consistent with a stroke;
- New objective neurological deficit identified via clinical examination and which continuous uninterrupted for at least sixty (60) days after the stroke is diagnosed;
- New changes identified on CT scan or MRI, which are consistent with the clinical diagnosis.

2.6.1 **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.

2.7 **Paralysis -** total loss of function of two or more limbs due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent by a neurologist. In case of such diagnosis, the Insurer shall pay 100% of the Sum Insured to the Beneficiary.

2.8 **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, the Insurer shall pay 100% of the Sum Insured to the Beneficiary.

2.9 **Pre-existing exclusions clause applicable to the insured children:**

2.9.1 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 seek 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.

3. KEY PROVISIONS AND INSURANCE PROCEDURE

3.1 Insured's age at inception shall be no less than 18 and no more than 61.

3.2 Upon signing the Contract, the Insured shall have the right to insure his/her child/children under the age of 18 for free.

3.3 Persons in need of constant care (assistance in daily activities) are not eligible for insurance. However, this restriction shall not apply to persons who find themselves in such a condition after conclusion of the Contract of Insurance.

3.4 As a precondition to concluding the Contract of Insurance, the Insured shall fill in and sign an application/questionnaire, confirming absence of diseases/health conditions listed on the application/questionnaire and/or examinations in relation to above diseases/health conditions undertaken prior to and/or during the signing stage of the Contract of Insurance. If the Insured is covered under cancer and/or critical illness insurance policy(ies) issued by another insurer(s), he/she shall indicate the amount of the Sum Insured in the same application/questionnaire. This application/questionnaire forms an integral part of the Contract of Insurance. If the answer to

the first question is "Yes", the person is not eligible for insurance. If the answer to the second, third and/or fourth questions is "Yes", the application shall be subject to personal underwriting, on the basis of which the Insurer shall have the right either to reject the application or modify the cover and/or adjust the premium. If information provided by the Insured on the application/questionnaire is false, incorrect or inaccurate, the Contract of Insurance shall be voided without return of premium and all claims filed with the Insurer shall be rejected.

3.5 The amount of Sum Insured which can be defined either in GEL or USD is chosen by the Insured.

3.6 If the Insured's child/children are insured under both parents' policy with identical Terms and Conditions, total indemnification in respect of the insured child shall be calculated as sum of Sum Insureds under both parents' policies (except for pre-invasive cancer, where Insurer shall issue only 10% of the total amount of both Sum Insureds).

3.7 By purchasing the Policy of Insurance under present Terms and Conditions, the Policyholder agrees and authorizes the Insurer, upon occurrence of an Insured Event, to request medical records/medical information from any medical institution and/or any third party, including personal information, necessary to determine circumstances of the Insured Event.

4. INSURANCE PREMIUM AND PAYMENT

4.1 Insurance premium shall be paid in GEL, either in lump sum or in installments. Premium payment frequency, payment terms and other key conditions are specified in the Insurance Policy.

4.2 If the Sum Insured is defined in USD, the Insurance Premium shall also be calculated in USD, but shall be paid in GEL at the rate of exchange established by the National Bank of Georgia on the date of payment.

4.3 The Insurer is free from any liability to pay the claim until single or first premium installment is paid under the Insurance Policy.

4.4 In case of multiple installments, if Policyholder fails to pay premium installment (i.e. any installment except the first one) in accordance with the premium payment schedule, the Policyholder shall have additional two weeks for the payment to be made. 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 reimbursed. After the expiry of 30 (thirty) calendar days after the due date (at 24:00 hours of the 30th day), Contract of Insurance/Policy shall be unilaterally terminated by the Insurer.

5. PERIOD OF INSURANCE AND CONTRACT TERM

5.1 This Contract of Insurance shall be concluded for a period of one (1) year and shall be renewed automatically on the same terms and conditions for another four (4) years after the end of the initial Period of Insurance as specified in the initial Insurance Policy.

5.2 This Contract of Insurance can be extended by mutual agreement of the parties, but shall be automatically terminated when the Insured turns 65. As for the insured child/children, the contract shall be automatically terminated when a child/children turn(s) 18.

5.3 This Contract of Insurance shall come into force at 24:00 hours of the start date of the Period of Insurance as specified in the Insurance Policy, provided single premium or first premium installment as specified in the Policy is paid by the Policyholder. This Contract of Insurance shall continue in full force and effect until 24:00 hours of the policy expiry date as specified in the Policy.

5.4 This Contract of Insurance may be terminated at the initiative of the Policyholder or the Insurer in accordance with the provisions contained in this Article.

5.4.1 The Insurer shall have the right to unilaterally terminate this Contract of Insurance without prior warning to the Policyholder and without setting an additional term:

5.4.1.1 If obligations assumed by the Insurer under the relevant Insurance Policy are fully discharged;

5.4.1.2 At the end of the insurance year, during which the Insured turned 65;

5.4.1.3 In case of death of the Insured or full payment of the Sum Insured;

5.4.1.4 In cases as provided for in paragraphs 4.3, 4.4 and 5.3 of present Terms and Conditions;

5.4.1.5 Upon expiry of the Policy period.

5.4.2 The Contract of Insurance shall also be terminated:

5.4.2.1 At any time, on the initiative of the Insurer by giving fourteen (14) calendar days notice to the Policyholder;

5.4.2.2 If the Insurer terminates its activities in accordance with the current legislation;

5.4.2.3 Based on preliminary written agreement of the parties;

5.4.2.4 In other cases as provided for by the Georgian legislation.

5.4.3 If the Policyholder wishes to terminate the insurance, he/she must notify the Insurer. The contract shall be terminated within five (5) calendar days of receipt of such written notice, provided no claim has been paid by the Insurer before the termination:

5.4.3.1 In case of a refundable premium, the Policyholder shall be entitled to a refund of the unearned portion of the total premium at the date of termination, less 10%;

5.4.3.2 In case of unpaid premium, the Insurer shall have the right to require payment of the unpaid part of the earned premium together with the 10% of the unearned premium at the date of termination.

5.4.4 Upon termination of the Insurance Policy by the Policyholder, if the Insured Event has occurred before termination, the unearned insurance premium shall not be refunded. In case of arrears, the Policyholder shall pay the premium in full.

5.4.5 Insurance for all Insureds shall be terminated if 100% of the Sum Insured is paid to the Principal Insured and shall not be renewed.

5.4.6 If 100% of the Sum Insured is paid to the Insured Child/Children, the Insurance Policy shall remain in force, but the insurance coverage in respect of this particular child/children shall be terminated and shall not be renewed.

6. WAITING AND SURVIVAL PERIODS

6.1 **Waiting Period -** a period of time during which Insurer is free from any liability to pay indemnity upon diagnosis of a Critical Illness covered by the Insurance Policy. Waiting Period is the first 90 (ninety) calendar days and is calculated from the Policy inception date. Waiting Period shall not apply to Insureds, who uninterruptedly renew Critical Illness Insurance Contract on same coverage terms and limits as specified in the previous policy.

6.2 Waiting Period shall not apply when the Insured's child who is insured under a parent's contract turns 18 and enters into an independent Contract of Insurance with the Insurer, on the same coverage terms.

6.3 If there is a gap between insurance periods or change in coverage, Waiting Period shall start again.

6.4 **Survival Period –** a period of time during which the Insured shall survive to be eligible for indemnification. In the event of death of the Insured during the Survival Period, no indemnity shall be paid.

6.5 Pursuant to this Terms and Conditions, Survival Period stands at 30 (thirty) calendar days and is calculated from the date of diagnosis and shall apply to Myocardial Infarction, Paralysis and Coronary Artery Bypass Surgery only.

7. OBLIGATION OF THE PARTIES

7.1 **The Policyholder / Insured shall:**

7.1.1 Provide the Insurer with all information/circumstances in his/her knowledge or information he/she should have known, that may affect risk assessment by the Insurer and/or the Insurer's decision to write the risk or change terms and conditions of the Insurance Policy;

7.1.2 Submit all documents required for claims settlement no later than thirty (30) calendar days from the date of the Insured Event;

7.1.3 Pay Insurance Premium in accordance with the premium payment schedule specified in the Insurance Policy.

7.2 **The Policyholder / Insured shall have the right to:**

7.2.1 Receive insurance indemnity in accordance with present Insurance Terms and Conditions.

7.3 **The Insurer shall:**

7.3.1 Arrive at the decision regarding claims settlement and pay respective indemnity to the Beneficiary or refuse to pay it in accordance with this Terms and Conditions within fifteen (15) business days from the date of submission of all documents by the Policyholder / Insured / Beneficiary;

7.3.2 Keep confidential and do not disclose any information obtained under the Contract of Insurance to any third party, unless otherwise requested for by the legislation of Georgia.

7.4 **The Insurer shall have the right:**

7.4.1 In assessment of the Insured Event, request from the Insured / Beneficiary to provide documents that are necessary to establish circumstances of the Insured Event and to arrive at the decision in regards to the indemnification;

7.4.2 To claim a refund if it is established that the Insured Event has not occurred;

7.4.3 To deduct unearned premium for the current insurance year and any outstanding premium from the claim amount;

7.4.4 To refuse the claim and cancel the Insurance Policy if forged documents / false information related to the Insured Event and/or indemnification are submitted. If the indemnity has already been paid, it shall be refunded unconditionally by the Insured / Beneficiary to the Insurer.

8. GENERAL EXCLUSIONS APPLICABLE TO CRITICAL ILLNESS COVER

8.1 Subject to this Terms and Conditions, no benefit shall be paid, and if paid, shall be refunded, if critical illness is directly or indirectly caused by, arises out of or is attributable to any of the following:

8.1.1 Voluntary participation in war (declared or undeclared), civil war, uprising, revolution, strike, military coup;

8.1.2 Suicide and self-harm;

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

8.1.4 Abuse of alcohol, drugs, toxic or psychotropic substances;

8.1.5 Participation in high-risk activities: combat sports, scuba diving, rock-climbing, mountaineering, parachuting, auto and motor racing, caving, mountain biking, extreme water sports, other extreme sports, aviation and air sports and others;

8.1.6 Involvement of the Insured in illegal activities provided for by the legislation of Georgia;

8.1.7 Failure to submit documents required by the Insurer to assess the claim in accordance with this Terms and Conditions;

8.1.8 If Policyholder/Insured provides incorrect and/or inaccurate and/or incomplete information during policy formation stage, which could have a significant impact on the risk assessment;

8.1.9 Failure to pay Insurance Premium or any part thereof as specified in Insurance Policy;

8.1.10 If documents and/or information related to the Insured Event provided by the Policyholder and/or the Beneficiary does not correspond to factual circumstances.

9. INDEMNIFICATION

9.1 The Policyholder/Insured/beneficiary shall notify the Insurer (hotline number +995 32 2 42 22 22 or e-mail: life@tbcinsurance.ge) no later than one (1) month from the date of diagnosis and submit the following documents: Claim form (application), a copy of the identity document of the Insured, Insurance Policy and a health certificate (form #IV-100/A, Medical History, conclusion of the histomorphological study, if necessary, results of other studies and relevant imaging tests).

9.2 The final diagnosis of a critical illness as confirmed by the Attending Physician shall be in line with the definition of the disease as specified in this Contract.

9.3 The Insurer reserves the right to request additional documents, other than those specified in this article, in order to accurately establish circumstances of the Insured Event (Including Birth Certificate(s) of the child (children)).

9.4 The Insurer reserves the right, to perform / request additional investigation / examination in order to corroborate the diagnosis or other circumstances.

9.5 The Insurer shall, after receiving all the required documents as specified in Articles 9.1 and 9.3, pay insurance indemnity to the Beneficiary under this Terms and Conditions, or refuse to indemnify the Beneficiary within 15 (fifteen) business days.

9.6 Regardless of the Policy currency, the Insurer shall pay indemnity in GEL at the exchange rate established by the National Bank of Georgia on the date of payment.

9.7 If the Insured is disabled, the indemnity shall be paid to his/her legal representative / guardian. If an Insured Event occurs during the Period of Insurance and is declared during the Insured's lifetime, but no indemnity is paid to the Insured until his/her death, the indemnity shall be paid to the Contingent Beneficiary as specified in the Insurance Policy.

10. NOTICES AND COMMUNICATION

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

10.2 The Insurer shall send a notice to the Policyholder / Insured to the address indicated in the Insurance Policy or, in case of any address change undertaken in accordance with this Terms and Conditions, to the latest address notified to the Insurer. Any notice / correspondence sent to such address shall be deemed received by the Policyholder / Insured, even if the addressee no longer resides at this address or the address is incorrectly / incompletely specified.

11. DISPUTE RESOLUTION

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

12. CONFIDENTIALITY

12.1 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 without preliminary consent of the other party, except where such disclosure is required by the current Georgian legislation or present Terms and Conditions.

12.2 The Insurer shall have the right to process personal data received in the course of concluding Insurance Contract for the purposes of: a) providing insurance services; b) protecting Insurer's interests, in case of non-performance by the Policyholder; and c) claims settlement, including, information requests from any private or public institution related to the Insured Event.

12.3 The Insurer shall have the right to process personal data for direct marketing purposes, namely to offer new insurance products and services. The data subject shall have the right 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, i.e. in writing or via telecommunication.

MEDICAL SECOND OPINION AND MEDICAL SERVICES ABROAD

This appendix shall form an integral part of Critical Illness Insurance Terms and Conditions.

DEFINITION OF TERMS

ATTENDING PHYSICIAN	Physician with relevant medical education, who holds state certificate confirming his/her right to engage in medical practice, and who has given advice to the Insured, prescribed and performed tests and by whom the initial diagnosis is made.
BUSINESS DAY	Official working days in Georgia and the USA.
WORKING HOURS	Official working hours in Georgia.
DIAGNOSIS	Diagnosis made by the 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, drawn up by the Attending Physician and/or other representative of the healthcare / medical institution in compliance with state standards. The documentation should include final diagnosis/diagnoses, the results and conclusions of physical, laboratory, instrumental and other examinations and recommendations for treatment.
PHYSICIAN	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, which is responsible for arranging Medical Second Opinion and medical services abroad under this Terms and Conditions.
MEDICAL CASE SUBJECT TO REVIEW	Illness or deterioration of health condition, which allows the Insured to request a review of his/her medical records for the purposes of Medical Second Opinion. All medical cases shall be subject to review, except for the following: ○ **No diagnosis** - the Insured shall have a 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 requiring immediate medical intervention that cannot be delayed for the purposes of obtaining Medical Second Opinion;
- **In order to study the problem, a physician needs to conduct in-person assessment of the patient.**

MEDICAL SECOND OPINION PROVIDED BY MEDIGUIDE	Means written report by a doctor working in the World Leading Medical Center, which incudes diagnosis and treatment recommendations, 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	Means medical facility recognized by the medical community as one of the leading clinics providing specialized medical care.
ASSISTANCE	A specialized company providing 24-hour telephone health 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 COVERED 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 After 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:

- 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 specified in this Contract.

1.1.11 Medical Second Opinion for the same diagnosis shall be prepared only once during the Period of Insurance under this Contract, unless health condition of the Insured has improved within the prescribed period, but such improvement was expected under the treatment guidelines, despite strict adherence to the treatment recommendations set out in the first Medical Second Opinion. In such a case, MediGuide shall provide a repeated Medical Second Opinion considering new circumstances.

2. ARRANGEMENT OF MEDICAL SERVICES ABROAD

2.1 According to this Terms and Conditions, MediGuide shall organize treatment recommended by the Medical Second Opinion at a medical institution chosen by the Insured outside of Georgia, together with travel and hotel accommodation related to this 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 shall organize such examinations abroad at the clinic chosen 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 specifying region/country as noted in recommendations provided by the Medical Second Opinion.

2.5.2 After obtaining written consent from the Insured, MediGuide shall deliver a copy of the Medical Second Opinion to its Partner (hereinafter referred to as the "MediGuide Partner"), which operates in the region chosen 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 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.

Application for Critical Illness Insurance

Date: _____

I hereby certify that the below statements are true and correct to the best of my knowledge.

I hereby confirm that I have never been diagnosed with:

- Any form of malignant tumor; Cancer; Leukemia; Lymphoma or other malignant disease;
- Angina; Ischemic heart disease; Myocardial infarction; Cardiac arrhythmias requiring treatment; Heart murmur; Rheumatism; Heart failure; Or other form of heart disease;
- Diabetes mellitus;
- Stroke, aphasia (trouble speaking, reading or writing);
- Epilepsy or paralysis.

I hereby certify that I am not currently undergoing examinations for the above listed diseases.

Name of the Insured:

Personal number:

Signature:

Questionnaire for Critical Illness Insurance

Date: _____

If yes, please specify.

1. Have you ever been treated for heart disease, stroke, diabetes mellitus, high blood pressure or a malignant tumor?

   ☐ Yes
   ☐ No

_____
_____

2. Have you taken or are you currently taking any medication in the form of pills, inhalers or otherwise (other than contraceptives) for 14 or more consecutive days in the last 3 years?
   ☐ Yes
   ☐ No

_____
_____

3. Do you suffer, or have you ever suffered from any illness / health problem in the last 10 years that requires regular medical check-ups (at least once a year)?

   ☐ Yes
   ☐ No

_____
_____

4. Have you seen a doctor in the last 12 months, or are you planning to visit a doctor in the near future due to a health problem, except for minor cases such as a cold or flu.

   ☐ Yes
   ☐ No

_____
_____

5. I have purchased cancer and/or critical illnesses insurance policy of other insurance company / companies.

☐ Yes
☐ No

Insurance period:

Sum Insured / Limit of Indemnity:

I hereby certify that the above statements are true and correct to the best of my knowledge.

I hereby agree to forward this questionnaire to JSC "TBC Insurance" for review.

Name of the Insured:

Personal number:

Signature: