

Splošni pogoji za prostovoljno zdravstveno zavarovanje oseb pri potovanju in bivanju v tujini z asistenco 01-ZZT-01/08

1. člen SPLOŠNE DOLOČBE

- (1) Splošni pogoji za prostovoljno zdravstveno zavarovanje oseb pri potovanju in bivanju v tujini z asistenco (v nadaljevanju: splošni pogoji) so sestavni del zavarovalne pogodbe, ki jo zavarovalec sklene z Adriatic Slovenico, zavarovalno družbo d.d. (v nadaljevanju: zavarovalnica).
- (2) Zavarovalec je oseba, ki sklene z zavarovalnico zavarovalno pogodbo; Zavarovanec je oseba, od katere bolezni, poškodbe ali smrti je odvisno povračilo nujnih stroškov zdravljenja ter prevoza in v korist, katere se sklene zavarovanje.
- (3) S pogodbo o prostovoljnem zdravstvenem zavarovanju oseb pri potovanju in bivanju v tujini z asistenco se zavarovalec zaveže, da bo zavarovalnici plačal premijo, zavarovalnica pa se obvezuje, da bo ob nastopu zavarovalnega primera zavarovancu povmila dokazane nujne stroške zdravljenja ter stroške prevoza, vendar največ do višine zavarovalne vsote.

2. člen OSEBE, KI JIH JE PO TEH POGOJIH MOGOČE ZAVAROVATI

- (1) Po teh splošnih pogojih se lahko sklene zavarovanje za zdrave osebe do dopolnjenega 70. leta starosti, ob povišani premiji pa tudi za osebe starejše od 70 let.
- (2) Duševno bolne osebe in osebe, ki nimajo popolne poslovne sposobnosti, so izločene iz zavarovanja.

3. člen SKLENITEV ZAVAROVANJA

- (1) Zavarovanje je potrebno skleniti pred začetkom potovanja. Zavarovanje, sklenjeno po pričetku potovanja, je neveljavno.
- (2) Zavarovanje je sklenjeno, ko zavarovalnica ali njena pooblaščenca oseba izda potrjeno zavarovalno polico. Zavarovalnica lahko pri pogodbah, sklenjenih na daljavo, določi, da je zavarovanje sklenjeno s samim plačilom premije.
- (3) Zavarovalec ima pravico, da v primeru, ko gre za pogodbo na daljavo, v roku 15 dni od dneva sklenitve zavarovanja odstopi od zavarovalne pogodbe. Odstop mora biti pisen in vložen na zavarovalnico do izteka roka, pri čemer se šteje, da je vložen v roku, če je do izteka roka priporočeno oddan na pošti. Zavarovalnica je v tem primeru upravičena obdržati premijo (stroške) za vsak dan, ko je nudila zavarovalno kritje. Zavarovalec nima pravice do odstopa od pogodbe pri zavarovalnih pogodbah z veljavnostjo, krajšo od enega meseca.

4. člen ZAČETEK IN TRAJANJE ZAVAROVANJA

- (1) Zavarovalno kritje se začne ob 00.00 uri tistega dne, ki je v polici naveden kot začetek zavarovanja, če je do takrat plačana zavarovalna premija in če se je do takrat potovanje že pričelo. Če zavarovalna premija do tedaj ni plačana, se začne zavarovalno kritje ob 00.00 naslednjega dne, ko je plačana. Enako velja za primer, če se potovanje začne kasneje.
- (2) Zavarovalno kritje preneha ob 24.00 uri tistega dne, ki je v polici naveden kot dan prenehanja zavarovanja.
- (3) Zavarovalno kritje je veljavno samo izven območja države stalnega bivališča zavarovanca.

5. člen OBSEG OBVEZNOSTI ZAVAROVALNICE

- (1) Zavarovalnica nudi asistenco in krije nujne stroške zdravljenja, stroške prevoza zavarovanca, ki so nastali v času potovanja in bivanja v tujini, razen v primerih, navedenih v 6. členu teh pogojev.
- (2) Asistenčne storitve klicnega centra CORIS v Ljubljani, 24 ur na dan in mreže CORIS po celem svetu, obsegajo:
 - organizacijo nujne zdravstvene pomoči,
 - organizacijo nujnih zdravstvenih prevozov zavarovanca,
 - obveščanje zavarovanca in njegovih najbližjih.
- (3) Nujni stroški zdravljenja obsegajo:
 - stroške medicinske oskrbe, obiska zdravnika, vključno z zdravili, izdanimi na zdravniški recept;
 - stroške hospitalizacije do dne, ko zdravstveno stanje zavarovanca le temu dovoljuje prevoz v državo stalnega prebivališča, kjer bo nadaljeval z zdravljenjem.
- (4) Stroški prevoza obsegajo:
 - stroške prevoza zavarovanca do najbližje bolnišnice ali klinike;

- stroške prevoza obolelega ali poškodovanega zavarovanca v domovino s predhodnim soglasjem CORIS centra, če se zavarovanec iz zdravstvenih razlogov ne more vrniti v domovino na način, kot je to prvotno nameraval;
 - stroške posmrtnih ostankov zavarovanca v domovino.
- (5) Dodatne stroške prevoza in stroške bivanja za osebo, ki na zahtevo oziroma po priporočilu lečečega zdravnika ostane v spremstvu zavarovanca, mlajšega od 18 let, oziroma stroške prevoza ožjega sorodnika iz domovine do kraja hospitalizacije, če mladoletnemu zavarovancu ni mogoče zagotoviti drugačnega spremstva.
- (6) Stroške prevoza zavarovančevega otroka, mlajšega od 18 let, do stalnega bivališča, kot tudi stroške prevoza njegovega spremljevalca v primeru zavarovančeve hospitalizacije ali smrti
- (7) Stroški, navedeni v 5. in 6. odstavku tega člena, se ne vrnejo brez predhodnega dovoljenja klicnega centra CORIS.
- (8) Za nujne stroške se štejejo stroški za storitve, ki so nujno potrebne za ohranjanje življenjskih funkcij ali preprečitev hudega poslabšanja zdravstvenega stanja nenadno obolelega ali poškodovanega zavarovanca.
- (9) Skupni znesek nujnih stroškov zdravljenja in stroškov prevoza na osebo, če so le-ti z medicinskega stališča upravičeni ter stroškov, navedenih v 5. in 6. odstavku tega člena, za vse zavarovalne primere, ki nastanejo v času trajanja zdravstvenega zavarovanja, ne sme presegati zneska 20.000 EUR oziroma zneska, navedenega v polici.

6. člen IZKLJUČITEV OBVEZNOSTI ZAVAROVALNICE

- (1) V celoti so izključene vse obveznosti zavarovalnice, če je primer nastal:
1. zaradi potresa;
 2. zaradi vojne v državi, notranjih nemirov in vstaj;
 3. zaradi terorizma;
 4. zaradi poskusa samomora ali naklepne samopoškodbe;
 5. zaradi vožnje motornih in drugih vozil brez ustreznih uradnih dovoljenj;
 6. pod vplivom alkohola, drog ali zdravil.
- (2) Zdravstveno zavarovanje tudi ne nudi asistenc in ne krije stroškov, nastalih kot posledica:
1. priprave ali udeležbe:
 - na avto-moto tekmovanjih ter pri vožnjah po dirkališčih;
 - v športnem letalstvu, padalstvu, pri letenju z zmaji in z jadralnimi letali;
 - pri alpinizmu;
 - pri smučanju in deskanju na snegu izven urejenih smučišč;
 - pri jamarstvu in pri ostalih ekstremnih športih;
 - pri planinarjenju in trekingu nad 3.000 metrov nadmorske višine, če to v polici ni posebej dogovorjeno;
 - pri potapljanju in podvodnem ribolovu, če to v polici ni posebej dogovorjeno;
 - pri prostem plezanju, če to v polici ni posebej dogovorjeno;
 - na drugih športnih tekmovanjih, če to v polici ni posebej dogovorjeno;
 2. vseh kroničnih bolezni, ponavljajočih izvinov in izpahov ter ostalih bolezni ponavljajočega se značaja oziroma poslabšanja že obstoječih bolezni;
 3. zdravljenja poškodb, ki so nastale pred začetkom trajanja zdravstvenega zavarovanja;
 4. psihičnih motenj;
 5. nalezljivih spolnih bolezni;
 6. nosečnosti, rednih pregledov v času nosečnosti, tipičnih težav v času nosečnosti ter poroda, razen v primeru reševanja življenja matere oziroma otroka, pod pogojem, da je nosečnica mlajša od 38 let in da ni zaključen 30.-ti teden nosečnosti;
 7. prekinitve nosečnosti;
 8. zobozdravstvenih storitev, razen nujne zobozdravstvene pomoči, ki je potrebna za odpravo akutne bolečine zaradi bolezni ali sveže poškodbe zobovja, vključno z ekstrakcijo zoba, do višine 100 EUR;
 9. posebne storitve v bolnišnici - nadstandard, kot je enoposteljna soba, telefon, TV, posebne nastanitve, itn).
 10. operacije ali zdravljenja, katerega se lahko prestavi brez kakršnihkoli posledic na čas povratka v državo stalnega prebivališča zavarovanca;
 11. nezgode pri profesionalnem fizičnem delu, če to v polici ni posebej dogovorjeno.
- (3) Zavarovalnica ne krije stroškov v naslednjih primerih:
1. če zavarovanec ne obvesti zavarovalnice ali njenih predstavnikov o nastanku zavarovalnega primera, telefonsko ali pisno, v roku 5 dni od začetka bolezni ali poškodbe;
 2. če ne spoštuje drugih navodil za uveljavljanje pravic iz zdravstvenega zavarovanja v primeru bolezni ali nezgode;
 3. če se na zahtevo zavarovalnice ne pusti pregledati zdravniku, ki ga imenuje zavarovalnica ali njeni predstavniki;
- (4) Izključene so vse obveznosti zavarovalnice v primeru dajanja neresničnih podatkov zavarovalca oziroma zavarovanca o trajanju potovanja, o okoliščinah poškodbe ali vrsti bolezni ter kakršnekoli prevar ali ponaredb.

7. člen OBVEZNOST ZAVAROVANCA

- (1) Zavarovanec mora zavarovalnici posredovati vse informacije, ki jih ta potrebuje za pravilno reševanje škodnega primera in mora poskušati omejiti stroške. V vsakem primeru mora zavarovanec ravnati po navodilih, ki jih dobi od zavarovalnice ali od njenih predstavnikov.
- (2) Če zavarovanec ni uporabil zdravstvene asistence in je nujne zdravstvene storitve skladno s 5. členom teh pogojev plačal sam, mu zavarovalnica povrne stroške po vrnitvi v državo stalnega prebivališča.
- (3) Stroški se povrnejo na osnovi sledečih dokumentov:
 - a) v primeru bolezni:
 - zdravstvene dokumentacije, ki opravičuje nujnost zdravljenja,
 - b) v primeru nezgode:
 - zdravstvene dokumentacije,
 - uradnega poročila ali potrdila, napisanega v tujini na podlagi okoliščin nesreče oziroma poškodbe,
 - c) v obeh primerih:
 - ene kopije zavarovalne police,
 - originalnega računa stroškov tuje zdravstvene pomoči,
 - dodatne dokumentacije na zahtevo zavarovalnice.

8. člen PRAVICE ZAVAROVALNICE

- (1) V primeru nezgode, ki jo povzroči tretja oseba, ima zavarovalnica pravico do povračila stroškov, ki jih je plačal zavarovancu, od povzročitelja nezgode.
- (2) Zavarovalnica si pridržuje pravico do regresa vseh nastalih stroškov v primeru, ko se naknadno ugotovi, da je zavarovalni primer nastal zaradi kronične bolezni, čezmernega uživanja alkohola ali zdravil in podobno.
- (3) Zavarovalec (po izrecnem pooblastilu zavarovanca - v primeru ko zavarovalec ni zavarovanec) s to zavarovalno pogodbo odstopa morebitno bodočo terjatev, ki bi jo imel zavarovanec na podlagi škodnega dogodka iz naslova obveznega zavarovanja do ZZS, zavarovalnici, ki mu je to terjatev odkupila, s tem ko je plačala stroške, ki bi jih sicer dobil povrnjene iz naslova obveznega zdravstvenega zavarovanja. Zavarovalnica lahko zahteva povračilo teh stroškov neposredno od ZZS.

9. člen PLAČILO PREMIJE

Zavarovalec je dolžan plačati zavarovalno premijo ob sklenitvi zavarovalne pogodbe.

10. člen ODPOVED POGODBE IN VRAČILO PREMIJE

- (1) Zavarovalec lahko odpove zavarovalno pogodbo v času, ko zavarovalno kritje še ni nastopilo - pred pričetkom potovanja v tujino.
- (2) Odpoved zavarovalne pogodbe je možna le v primeru, če potovanje odpade zaradi smrti ali bolezni zavarovanca ali ožjega družinskega člana. Odpoved v nobenem primeru ni možna po začetku zavarovalnega kritja.
- (3) V primeru odpovedi zavarovalne pogodbe zavarovalnica vrne 85% plačane premije.

11. člen VARSTVO OSEBNIH PODATKOV

- (1) Zavarovalec oziroma zavarovanec v skladu z Zakonom o varstvu osebnih podatkov dovoljuje, da se njegovi osebni podatki uporabljajo v zbirki podatkov, ki jo vzpostavi, vodi in vzdržuje zavarovalnica in z njim kapitalsko povezana ter pooblaščen podjetja za zastopanje in posredovanje zavarovanj.
- (2) Zavarovalec (po izrecnem pooblastilu zavarovanca v primeru ko zavarovalec ni zavarovanec) dovoljuje zavarovalnici in njenemu pooblaščenцу vpogled v zdravstveno dokumentacijo zavarovanca.
- (3) Navedeni osebni podatki se bodo uporabljali le v času zavarovanja in z namenom obveščanja zavarovalca oziroma zavarovanca o novostih in ponudbah zavarovalnice. Zavarovalnica se obvezuje, da bo zdravstvene podatke, kot vse druge osebne podatke, skrbno varovala v skladu z veljavno zakonodajo.

12. člen IZVENSODNO REŠEVANJE SPOROV

- (1) Zoper odločitev zavarovalnice je dovoljena pritožba. Pritožba se vložijo na tisto organizacijsko enoto zavarovalnice, kjer je bilo sklenjeno zavarovanje. Pritožba se lahko odda osebno, po pošti ali prek spletne strani zavarovalnice.
- (2) Pritožbo obravnava pristojna pritožbena komisija v skladu s pravilnikom, ki ureja interni pritožbeni postopek zavarovalnice. Odločitev pritožbene komisije je dokončna in nadaljnji postopki pri zavarovalnici niso možni.

- (3) V primeru nestrinjanja z odločitvijo pritožbene komisije , se lahko po posebnem dogovoru nadaljuje postopek za izvensodno rešitev spora pri mediacijskem centru, ki deluje v okviru Slovenskega zavarovalnega združenja.

13. člen ZAKLJUČNA DOLOČILA

- (1) Za razmerja pri zavarovalni pogodbi se uporablja slovensko pravo. Za spore iz te zavarovalne pogodbe je krajevno pristojno sodišče po kraju organizacijske enote zavarovalnice, pri kateri je bila zavarovalna pogodba sklenjena.
- (2) Za izvajanje nadzora nad zavarovalnico je pristojna Agencija za zavarovalni nadzor, Trg republike 3, Ljubljana.

Summary of the Conditions for Voluntary Health Insurance

TRANSLATION: Only the Slovene version shall be legally binding

Article 1 GENERAL PROVISIONS

- (4) General Conditions for voluntary health insurance during travelling and residence abroad with assistance (hereinafter referred to as General conditions) are constituent part of the insurance contract, concluded between Policyholder and ADRIATIC SLOVENICA, Insurance Company Ltd. (hereinafter referred to as Insurer).
- (5) Policyholder is a person, who enters into an insurance contract with the Insurer; Insured is a person, upon whose illness, injury or death the compensation of urgent medical treatment as well as transport costs shall depend and to the benefit of whom the insurance is concluded.
- (6) By the contract on voluntary health insurance during travelling and residence abroad with assistance the Policyholder shall be obliged to pay the Premium to the Insurer, and the Insurer shall be obliged to at insurance case occurrence reimburse to the Insured proven urgent costs of medical treatment as well as transport costs, however to the amount of sum insured at most.

Article 2 INSURABLE PERSONS ACCORDING TO THESE CONDITIONS

- (3) According to these General Conditions the insurance may be concluded for healthy persons till their fulfilled 70th year, against additional premium payment however also for persons older than 70 years.
- (4) Mentally ill persons and persons without full contractual capability, shall be excluded from the insurance.

Article 3 CONCLUSION OF INSURANCE

- (4) The insurance must be concluded prior to starting date of the journey. The insurance concluded after the starting date of the journey shall not be valid.
- (5) The insurance shall be concluded, when a certified insurance policy is issued by the Insurer or his authorized person. The Insurer may in contracts concluded on the distance define that the insurance shall be concluded by premium payment.
- (6) The Policyholder has a right to, in case of contract on the distance, rescind this contract within 15 days since the date of insurance conclusion. Rescission must be in writing and filed to Insurer till the end of the due date, whereat it shall be regarded to be filed within due date, if till the end of due date it was posted by registered mail. The Insurer shall in this case be entitled to keep the premium (costs) for each day of offering insurance cover. The Insurer has no right to rescind a contract in insurance contracts valid for less than a month.

Article 4 COMMENCEMENT AND EXPIRATION OF INSURANCE

- (4) The insurance cover starts at 00.00 hrs of the day stated in the policy as the insurance commencement date, if the insurance premium was paid till that day and the travel has already begun by that day. If the insurance premium is not paid till that day, the insurance cover shall commence at 00.00 of the next day, after the premium was paid. Same applies also in case, if the travel starts later.
- (5) The insurance cover ceases at 24.00 hours of the day stated as the termination day in the insurance policy.
- (6) The insurance cover shall only apply outside the state area of Insured's permanent residence.

Article 4 SCOPE OF THE INSURER'S OBLIGATIONS

- (5) The Insurer shall offer assistance and cover the urgent medical treatment and transport costs of the Insured, which occurred during travelling abroad, except in cases stated in Article 6 of these Conditions.
- (6) (2) Assistance services of a CORIS Call Centre in Ljubljana, 24 hours per day and of CORIS net around the world, include:
 - organisation of urgent medical aid,
 - organisation of urgent medical transport of the insured,
 - advising the insured and his nearest relatives.
- (7) Urgent medical costs comprehend:
 - costs of medical treatment, doctor's visit, including medications, given against prescription;
 - costs of hospitalisation till the day, when Insured's state of health permits him transportation to the state of permanent residence, where he shall continue the treatment.
- (8) Transport costs include:
 - transport costs of the Insured to the nearest hospital or clinic;
 - transport costs of the sick or injured Insured to his homeland according to prior consent of CORIS centre, if the insured should for reasons of health be unable to return to his homeland in the originally intended manner;
 - transport costs of Insured's mortal remains to his homeland.
- (5) Additional transport and residence costs for a person, which under request or according to recommendation of attending physician, remains in attendance of an Insured under 18 years, or transport costs of a close relative from homeland to the hospitalisation place, if a minor Insured can not be provided with another attendance.
- (6) Transport costs of the Insured's baby, younger than 18 years, to the address of permanent residence as well as transport costs of his attender in case of Insured's hospitalisation or death
- (7) Costs stated in Paragraph 5 and 6 of this Article shall not be refunded without prior permit of CORIS Call Centre.

- (8) As urgent costs shall be considered costs for services, which are urgently necessary for vital functions preservation or for prevention from serious deterioration of suddenly sick or injured Insured's medical condition.
- (9) Total amount of urgent medical treatment costs and transport costs per person, if justified from the medical point of view, as well as costs, stated in Paragraph 5 and 6 of this Article, for all insurance cases occurred during health insurance duration, must not exceed the amount of 20.000 EUR or the amount stated in the insurance policy respectively.

Article 6 EXCLUSIONS FROM THE INSURER'S OBLIGATIONS

- (5) Entirely excluded shall be all Insurer's obligations, if the case occurred due to:
 7. earthquake;
 8. war events, riots or rebellions in the state of policyholder;
 9. terrorism;
 10. attempted suicide or wilfully self inflicted injuries;
 11. driving motor vehicles or any other vehicles without appropriate official licences;
 12. excessive consumption of alcohol, drugs or narcotics.
- (6) Health insurance shall also not offer assistance and shall not cover costs, occurred as a result of:
 12. training or participation:
 - in any motor competitions as well as when driving on racecourses;
 - in sport aviation, parachuting, hang-gliding and gliding;
 - in mountain climbing;
 - in skiing and snowboarding out of ski resorts;
 - in speleology and other extreme sports;
 - in mountaineering and trekking above 3.000 meters above sea level, unless especially agreed in the insurance policy;
 - at diving and underwater fishing, unless especially agreed in the insurance policy;
 - free climbing, unless especially agreed in the insurance policy;
 - in other sport competitions, unless especially agreed in the insurance policy;
 13. all chronic diseases, repeated dislocations and sprains as well as other diseases of recurrent nature or deterioration of pre-existing illnesses ;
 14. medical treatment of injuries, which occurred before the health insurance commencement;
 15. mental disorders;
 16. infectious sexual diseases;
 17. pregnancy, routine physical examinations during pregnancy, typical complications during pregnancy and childbirth except for saving mother's or child's life, under condition that expectant mother is younger than 38 years and has not yet ended the thirtieth (30th) week of pregnancy;
 18. induced abortion;
 19. dental treatment except for urgent dental treatment, necessary for suppressing acute pain due to illness or fresh injury of teeth, including tooth extraction, up to the amount of 100 EUR;
 20. special services in the hospital - higher standard, such as single room, telephone, TV, special accommodations, etc.);
 21. operation or medical treatment, which can be postponed without any consequences to the time of returning into the state of Insured's permanent residence;
 22. accidents in professional physical work, unless especially agreed in the insurance policy.
- (7) The Insurer shall not cover costs in following cases:
 4. if the Insured does not inform the Insurer or its representatives, either by phone or letter, about the case at least 5 days from the starting date of sickness or injury;
 5. if he does not follow other instructions for asserting his rights from health insurance in case of illness or accident;
 6. if he on the Insurer's request does not accept medical examination by a doctor nominated by the Insurer or its representatives;
- (8) Excluded shall be all Insurer's obligations in case of Policyholder's false data statements regarding journey duration, any fraud or forgery.

Article 7 INSURED'S OBLIGATIONS

- (4) The Insured must deliver any information to the Insurer, that he requires for proper claim settlement and must make an attempt to restrain the costs. In any case is the Insured obliged to handle according to instructions, given to him by the Insurer or his representatives.
- (5) If the Insured has not employed medical assistance and has paid the urgent medical services according to Article 5 of these Conditions by himself, the Insurer shall reimburse costs after his return to the state of permanent residence.
- (6) Costs shall be reimbursed based on following documents:
 - a) in case of illness:
 - medical documentation exculpating the medical treatment emergency,
 - b) in case of accident:
 - medical documentation,
 - official report or confirmation, written in foreign country based on circumstances of accident or injury respectively;

c) in both cases:

- one copy of insurance policy,
- original invoice for costs of foreign medical aid,
- additional documentation on the Insurer's request.

Article 8 INSURER'S RIGHTS

- (4) In case of accident, caused by the third party, the Insurer has a right to the reimbursement of costs, paid by him to the Insured, from the person responsible for the accident.
- (5) The Insurer reserves the right of recourse for all costs occurred when subsequently established that the insurance case occurred due to chronic disease, excessive consumption of alcohol or drugs and suchlike.
- (6) By this insurance contract the policyholder shall (according to explicit authority by the Insured - in case Policyholder and Insured are not the same person) assign an eventual future claim, which the Insured would have had based on loss event in respect of compulsory insurance against ZZZS, to the Insurer, which redeemed this claim from him by paying costs, which otherwise would be reimbursed in respect of compulsory health insurance. The Insurer may request a reimbursement of these costs directly from ZZZS.

Article 9 PREMIUM PAYMENT

The Policyholder is obliged to pay the insurance premium when concluding the insurance contract.

Article 10 NOTICE OF TERMINATION OF A CONTRACT AND PREMIUM REPAYMENT

- (4) The Policyholder may give a notice of a termination of insurance contract within the period, when the insurance cover has not yet begun - before commencing travelling abroad. ns.
- (5) The notice of termination of insurance contract is only possible in case the journey does not take place due to death or illness of the Insured or close family member. Notice of termination shall in no case be possible after the commencement of insurance cover.
- (6) In case of notice of termination of insurance contract the Insurer shall reimburse 85% of premium paid.

Article 11 PROTECTION OF PERSONAL DATA

- (4) In line with the Personal Data Protection Act the Policyholder or the Insured respectively authorizes the use of personal data from the Application and the Enrolment Form in the database that is established, administered and maintained by the Insurer and its associated companies and companies authorized by it for agency and brokerage services.
- (5) The Policyholder (by explicit authority of the Insured in case the Policyholder and the Insured are not the same person) allows the Insurer and his mandatory to examine the medical documentation of the Insured.
- (6) Stated personal data will only be used during the term of insurance for the purpose of informing the Policyholder or the Insured respectively about the Insurer's novelties and offers. The insurer is obliged to carefully protect medical data as well as all other personal data in accordance with legislation in force.

Article 12 OUT-OF-COURT SETTLEMENT OF DISPUTES

- (1) An appeal is permissible against decisions made by the Insurer. An appeal should be filed at the branch of the Insurer where the insurance was concluded. An appeal may be filed either personally, by post or through the website of the Insurer.
- (2) An appeal shall be tried by the competent appellate commission in compliance with the directive regulating internal appellate procedure of the Insurer. The decision of the appellate commission is final and further procedures by the Insurer are not feasible.
- (3) In case of disagreement with the decision of the appellate commission, the out-of-court settlement may by special agreement continue at the Mediation procedure Centre operating within the Slovenian Insurance Association.

Article 12 FINAL PROVISIONS

- (3) For relations in insurance contract Slovenian law shall apply. A territorial jurisdiction for disputes from this insurance contract has a court according to the site of insurer's organisational unit, in which the insurance contract was concluded.
- (4) For implementation of the supervision over the insurer is competent Agency for insurance supervision, Trg republike 3, Ljubljana.