 RULES
of comprehensive insurance of citizens traveling within the Russian Federation
(model (uniform) rules)
No. 184
(as amended by Order No. 53 dated 23.10.2012 of Rosgosstrakh OJSC; as amended by Order No. 57 dated 27.02.2014 of Rosgosstrakh OJSC; as amended by Order No. 123 dated 01.12.2014 of Rosgosstrakh OJSC; as amended by Order No. 322 dated 30.05.2016 of Rosgosstrakh IC PJSC; as amended by Order No. 243 dated 01.08.2017 of Rosgosstrakh IC PJSC)

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SECTION 1. GENERAL PROVISIONS

1. INSURANCE ENTITIES

1.1. In accordance with the laws of the Russian Federation and on the basis of these Insurance Rules (hereinafter referred to as the “Rules”), Rosgosstrakh Insurance Company Public Joint Stock Company (Rosgosstrakh IC PJSC), hereinafter referred to as the “Insurer”, concludes with relevant individuals and legal entities (hereinafter referred to as the “Policyholder”) the Contracts of Comprehensive Insurance of Citizens Traveling within the Russian Federation, hereinafter referred to as the “Insurance Contracts” or “Contracts”.

1.2. Under the terms of these Rules the Insurance Contracts are concluded with the Policyholder which may be Russian or foreign:

1.2.1. individuals with full legal capacity (according to Article 21 of the Civil Code of the Russian Federation);

1.2.2. legal entities of any legal form.

1.3. The insured person is an individual named in the Insurance Contract Traveling within the Russian Federation who resides and stays in the Russian Federation in favor of whom the Insurance Contract is concluded against the possibility of occurrence of an event (an event insured) specified in the Insurance Contract.

The insured persons may be citizens of the Russian Federation, foreign citizens and stateless persons who permanently reside (on the basis of a residence permit) or temporarily reside on the territory of the Russian Federation (legally).

1.4. The insured persons may be persons whose age is not more than 65 years as of the expiration of the insurance period. Persons whose age is 65 years or more as of the expiry of the insurance period may be insured on condition that the insurance premium is paid in accordance with raising age coefficients, the Insurance Contract (Policy) under the heading “Special Conditions” indicates the extension of the insurance coverage with the special condition “Age” according to clause 3.4.2. of these Rules, unless otherwise specified in the Insurance Contract.

1.5. For the purposes of these Rules, a spouse, parents, children, adoptive parents, adopted children, siblings, grandmothers, grandparents, official guardians and wards, grandchildren are recognized as “close relatives”.

1.6. These Rules, the Insurance Contract may provide for special restrictions on the underwriting, the effect of insurance stipulated by the Insurance Contract, which relate to age; state of health (disability); pregnancy; chronic disease; sports, active rest, professional activities of the Insured Person; territory of insurance and other conditions.

1.7. Under the Civil Liability Insurance Contract for liabilities arising as a result of causing harm to the life, health and/or property of third parties, the risk of liability of the Policyholder himself (if the Policyholder is an individual) or another individual to which such liability may be charged (hereinafter – the Insured Person), may be insured. Such an individual must be named in the Insurance Contract. If the Policyholder is an individual and the Insured Person is not named in the Insurance Contract, then the Insured Person is the Policyholder (i.e., the Policyholder’s own risk of liability is considered to be insured). If the Policyholder is a legal entity, and the Insured Person is not named in the Insurance Contract, such Insurance Contract is void in the part of insurance of civil liability. The Civil Liability Insurance Contract may only be concluded with the Policyholder being an individual or a
legal entity with regard to risks not related to the professional activities of the Policyholder and the Insured Person.

2. INSURED PROPERTY
2.1. The insured property under the Contracts concluded under these Rules is the property interests of the Policyholder (the Insured Person) that are not in conflict with the legislation of the Russian Federation, related to
- the payment for the arrangement and rendering to the Insured Person of medical and medicinal assistance (medical services), other services due to a disorder in the state of health of the Insured Person, requiring the arrangement and rendering of such services (“Medical and Emergency Assistance” risk);
- the risk of unforeseen expenses arising from the cancellation or delay of a flight or the cancellation of a paid trip (“Trip Cancellation” risk);
- causing harm to health, as well as to the death of the Insured Person as a result of an accident, a dangerous disease (“Accident” risk);
- the risk of loss (death) and/or delay of luggage (“Luggage” risk);
- the risk of liability for causing harm to life, health and/or damage to property of third parties (“Civil Liability” risk).

3. EVENTS INSURED. RISKS INSURED. SPECIAL INSURANCE CONDITIONS
3.1. The event insured is an event occurred as provided by the Insurance Contract, which results in the Insurer’s obligation to make an insurance payment.
3.2. The risk insured is a potential event for occurrence of which the insurance is carried out.
3.3. The list of events and risks insured and the insurance conditions are given in the relevant sections of these Rules. The Insurance Contract may be concluded with the condition of providing insurance cover for the risks provided for in these Rules, namely:
- “Medical and Emergency Assistance” risk;
- “Trip Cancellation” risk;
- “Accident” risk;
- “Luggage” risk;
- “Civil Liability” risk.
3.4. If this is specifically stipulated by the Insurance Contract, the liability of the Insurer may be extended subject to application of the raising coefficients established by the Insurer for the following special conditions:

3.4.1. “Sports” means the going by the Insured in for sports, participation in trainings, in competitions of sportsmen in professional or amateur sports, and also active rest.

“Active rest” means a way of spending free time during which a person having a rest engages in active activities that require active physical work of the body, work of the muscles of the whole body. For the purposes of these Rules, the following activities of the Insured Person are considered as active rest: aqua aerobics, aerobics; athletics (light, heavy); aikido; car racing; aquathlon; acrobatic rock and roll; arm-wrestling; badminton; basketball; boxing and its varieties; wrestling (free-style, Greco-Roman, belt); run; baseball; base
jumping/rope jumping/bungee (zip wire); biathlon; bobsled; bowling; wakeboard; water motorcycles; water skiing; water polo; windsurfing; cycling (track, highway); volleyball, including beach one; handball, including beach one; weight-lifting; rowsport (boat racing, rowing and canoeing); rowing slalom; gymnastics (any type); skiing; golf; gorodki sports; diving; judo; dillig; off-road; ball games (any type); yoga; capoeira; skating, speed skating; kayaking; kiting; carting; skating (boating and yachting, roller-skating, sledding); canoe; curling; cricket; kudo; cross country skis; mountain bike; motorcycle races; staying in a sauna, aqua park; hunting, including underwater one; sailing; jumping (water jumps, trampolining, ski jumping); rides (moped, motorcycle, motor scooter, quad bike, snowmobile, scooter, motobike); parachuting; parkour; paintball; powerlifting; petanque; rides/walks/movement by different kinds of animals or types of sport related to animals; rafting; fishery; fishing (sportfishing); water entertainment with the use of towed inflatables and parachutes; sambo; luge; safari; jeep safari; surfing; snowboarding; snorkeling; descent into the caves; skateboarding; squash; race walking, orienteering; softball; shooting (any type); synchronized swimming; trekking; taekwondo; dancing; tennis (court, table); tourism (military, sports, motorcycle); wushu; ukado; fencing; figure skating; football, including beach one; floorball; hockey (ice hockey, field hockey); hapkido; cheerleading; short track speed skating; any walks in the mountains outside the settlement or the hotel territory, including hill climbing, crossing passes, keeping abreast with cliffs and steep slopes.

For the purposes of these Rules, trekking refers to a walking tour that does not involve the use of sports/special climbing equipment, special clothing for climbing and is not part of a climbing route.

“Amateur sports” means systematic going in for a selected sport or exercise, participation in sports competitions, trainings on the basis of voluntariness.

“Professional sports” means going in for sports as the main activity and receipt of wages or other monetary compensation under a contract for the preparation for and participation in sports competitions;

3.4.2. “Age” means the age of the Insured Person as of the date of expiration of the Insurance Contract being 65 years or more;

3.4.3. “Profession” means the absence of restrictions on the professional activities of the Insured Person and the performance of works under an employment contract;

3.4.4. “Chronic disease” (for “Medical and Emergency Assistance” risk only) means the inclusion in the insurance coverage (liability of the Insurer) of aggravation or complication of the Insured Person’s chronic illnesses that endanger life, regardless of whether they were known to the Insured Person at the beginning of the trip or not. The Insurer pays expenses for each Insured Person under the Contract for “Medical and Emergency Assistance” risk for each event insured in the amount not exceeding 20 (twenty) percent of the sum insured as specified in the Contract, unless otherwise provided by the Contract.

In these Rules, chronic diseases are defined as the diseased state of an organ or system of the body which is characterized by a prolonged course, including asymptomatic, the presence of exacerbations and complications, both primary and repeated, that require treatment, including recur;

3.4.5. “Pregnancy” (for “Medical and Emergency Assistance” risk only) means the inclusion in the insurance coverage (liability of the Insurer) of sudden acute complications of pregnancy and premature birth, including as a result of an accident. The Insurer shall bear
liability in the amount not exceeding 20 (twenty) percent of the sum insured as specified in the Contract per Insured Person for “Medical and Emergency Assistance” risk per each event insured, provided that as of the date of the declared event, the pregnancy period was no more than 31 (thirty one) weeks of pregnancy, inclusive, unless otherwise provided by the Contract. Expenses under the condition “Pregnancy” associated with the occurrence of an event after 31 (thirty-one) weeks of pregnancy are not paid for.

3.5. In these Rules, the insurance coverage, as well as the liability of the Insurer refer to a set of insurance conditions stipulated by the Insurance Contract (Policy) concluded and these Rules.

3.6. Risks insured as chosen by the Policyholder, as well as changes in insurance coverage reflected in the special conditions provided for in these Rules are specified in the Insurance Contract.

4. SUM INSURED. INSURANCE RATE. INSURANCE PREMIUM (INSURANCE CONTRIBUTION). FRANCHISE

4.1. The sum insured is a sum of money which is determined in accordance with the procedure established by the Insurance Contract upon its conclusion, and on the basis of which the amount of the insurance premium (insurance contribution) and the amount of insurance payment is determined upon the occurrence of the event insured.

Within the sum insured as established separately for each risk, in accordance with the Insurance Contract or these Rules, limits of sums insured, insurance payments, as well as the share of the Policyholder/Beneficiary/Insured Person in the loss (franchise) may be established.

The sum insured for each risk is aggregate, i.e. after each insurance payment of a part of the sum insured, the remaining sum insured is reduced by the amount of the payment made, unless otherwise provided by the Contract.

4.2. The insurance rate is a rate of insurance for the exposure unit taking into account the insured property and the nature of the risk insured, as well as other insurance conditions, including the presence of the franchise and its amount in accordance with the insurance conditions and information provided by the Policyholder at the time of conclusion of the Insurance Contract.

4.3. The insurance premium (insurance contribution), hereinafter referred to as the insurance premium, is an insurance fee that the Policyholder must pay to the Insurer upon the conclusion of the Insurance Contract.

4.3.1. The insurance premium is established in rubles or in another currency equivalent to a certain amount in rubles. When establishing an insurance premium in foreign currency, the insurance premium is paid in rubles at the official exchange rate of foreign currencies set by the Central Bank of the Russian Federation as of the date of conclusion of the Insurance Contract, unless otherwise stipulated in the Insurance Contract;

4.3.2. in these Rules, a conditional unit refers to a foreign currency in which the sum insured/insurance premium under the relevant Insurance Contract is expressed;

4.3.3. unless the Insurance Contract provides otherwise, the insurance premium is paid by the Policyholder at a time in full for the entire period of insurance upon the conclusion of the Insurance Contract;
4.3.4. unless the Insurance Contract provides otherwise, the date of payment of the insurance premium is:

4.3.4.1. under the Insurance Contracts concluded with individuals – the date prescribed in accordance with Article 37 “Work (rendered services) payment procedure and terms” of the Law “On Protection of Consumer Rights”;

4.3.4.2. under the Insurance Contracts concluded with legal entities – the date of receipt of the insurance premium (insurance contribution) on the Insurer’s settlement account or payment of the insurance premium (insurance contribution) in cash to the Insurer/authorized representative of the Insurer.

4.4. The franchise being a part of the loss that is determined by the Insurance Contract is not subject to reimbursement by the Insurer to the Policyholder or any other person whose interest is insured in accordance with the terms of the Insurance Contract, and is established as a certain percentage of the sum insured or a fixed amount, in days or other time period during the period of insurance prescribed by the Insurance Contract.

4.4.1. In the Insurance Contract (Policy) under these Rules, an unconditional franchise may be established – the amount of insurance payment is defined as the difference between the amount of the loss and the amount of the franchise;

4.4.2. in the Insurance Contract (Policy) under these Rules, a time franchise (unconditional) may be established – the period of time during which any losses and expenses are not subject to reimbursement by the Insurer to the Policyholder or to any other person whose interest is insured in accordance with the terms of the Insurance Contract.

5. INSURANCE TERRITORY. TERM OF THE INSURANCE CONTRACT. INSURANCE PERIOD

5.1. The Insurance Contract is valid within the insurance territory – the Russian Federation, outside the administrative boundary of the settlement which is the place of residence of the Insured Person, unless otherwise stipulated in the Insurance Contract.

5.2. The insurance stipulated by the Insurance Contract concluded under the terms of these Rules does not apply to the following territories, unless otherwise stipulated in the Insurance Contract:

5.2.1. for citizens of the Russian Federation: to the territory located within the administrative boundary of the settlement which is the place of residence of the Insured Person.

In these Rules, the place of residence of the Insured citizens of the Russian Federation means:

- a) a place of permanent residence – according to the entry of registration in an identity document;
- b) a place of stay – according to a standard document confirming registration at the place of temporary stay for more than 1 (one) month, as well as a place of work or a place of study;

5.2.2. to the territory where military operations or military anti-terrorist operations are conducted, armed conflicts and clashes take place;

5.2.3. to the territory within which pest-spots are detected and officially recognized;

5.2.4. to the territory that the government bodies or organizations of the Russian Federation do not recommend for visiting.
5.3. The term of the Insurance Contract (the period of time during which the Insurance Contract is valid) is established by agreement of the parties on a case-by-case basis. Unless otherwise provided by the Insurance Contract, the Contract enters into force based on the time of the place of issue of the Contract at 00 hours 00 minutes on the day specified in the insurance policy as the effective date of the Contract, but in any case not earlier than the date of payment by the Policyholder of the insurance premium (insurance contribution), and expires based on the time of the place of issue of the Contract at 23 hours 59 minutes on the day specified in the insurance policy as the date of expiry of the Insurance Contract.

5.4. If, at the time of conclusion of the Insurance Contract, the Insured who is a foreign citizen or a stateless person has already been in the territory of the Russian Federation, then a time franchise is valid for it for a period of 5 (five) calendar days from the date of execution of the Contract (Policy), unless otherwise expressly provided in the Contract (Policy).

5.5. Insurance stipulated by the Insurance Contract concluded under the terms of these Rules is valid from 00 hours 00 minutes on the day following the date of entry into force of the Contract, unless otherwise provided by the Insurance Contract.

5.6. The period of insurance is the maximum aggregate insurance period within the scope of the Contract declared by the Policyholder/Insured Person and agreed upon by it.

5.7. The insurance period under the Contract:

5.7.1. may be equal to the number of insured days of the Insured Person’s stay in the insurance territory;

5.7.2. may exceed the number of insured days of the Insured Person’s stay in the insurance territory.

5.8. In these Rules, the number of insured days means the number of days of stay in the insurance territory during which the insurance coverage specified in the Policy in the column “Number of Insured Days” is valid.

The number of insured days counts from the first day of entry into the insurance territory.

5.9. The period of insurance for “Medical and Emergency Assistance”, “Accident”, “Luggage”, “Civil Liability” risks is established, unless otherwise provided by the Insurance Contract:

5.9.1. for citizens of the Russian Federation: from the moment of crossing by the Insured Person of the administrative boundary of the settlement which is a place of residence of the Insured Person, but not earlier than the start date of the insurance period specified in the insurance Policy, and until the Insured Person crosses the administrative boundary of the settlement which is a place of residence of the Insured Person upon return from a trip, but not later than the expiry date of the insurance period specified in the insurance Policy;

5.9.2. for foreign citizens or stateless persons: from the moment of crossing the state border of the Russian Federation as certified by an entry of the border service in the passport, or as from the beginning of the insurance period.

5.10. The period of insurance for “Trip Cancellation” risk is equal to the term of the Insurance Contract, is calculated at the place of conclusion of the Contract specified in the insurance Policy and is established from 00 hours 00 minutes of the day specified in the insurance Policy as the effective date of the Contract at the place of conclusion of the Contract, until 23 hours 59 minutes of the day specified in the insurance Policy as the expiry date of the Contract (in respect to each Insured Person).
5.11. Insurance stipulated by the Insurance Contract is valid during the period of insurance indicated as the insured number of days in the Policy in the column “Number of Insured Days”.

5.12. At each entry of the Insured Period into the insurance territory, the number of insured days of the Insured Person’s stay in the insurance territory is automatically reduced by the number of days spent in the insurance territory in the previous trips of the Insured Person. In this case, the Insurer’s liability is terminated upon expiration of the limit of the insured days established in the column “Number of Insured Days”, or expiry of the insurance period, whichever is the earliest.

5.13. If by the end of the insurance period the return of the Insured Person to the place of residence is impossible due to the event insured associated with 24-hour in-patient treatment and in the presence of a corresponding medical report, the Insurer’s liability for this event insured is extended additionally for a period of not more than 10 (ten) calendar days from the end of the limit specified in the column “Number of Insured Days” or the expiry of the insurance period, whichever is the earliest. At the same time, the Insurer’s liability does not extend to the coverage of any expenses after 10 (ten) calendar days, including expenses related to the return of the Insured Person to the place of residence, medical transportation or repatriation of a deceased body. The Insurer is not liable for other events that occurred during this period which have signs of an event insured, and the relevant events are not recognized as events insured.

5.14. If, at the time of conclusion of the Insurance Contract, the Insured citizen of the Russian Federation is already outside the administrative boundary of the settlement which is a place of residence of the Insured Person, insurance does not extend to this trip, unless otherwise expressly provided for in the Contract (Policy).

6. CONCLUSION AND PERFORMANCE OF THE INSURANCE CONTRACT

6.1. The Insurance Contract is an agreement between the Insured and the Insurer by virtue of which the Insurer undertakes to make an insurance payment for the contractual insurance premium (insurance contribution) upon occurrence of an event specified in the Insurance Contract (an event insured) within the sum insured established by the Contract.

6.2. When concluding the Insurance Contract, the Policyholder is obliged to provide the Insurer with reliable information that is relevant for determining the risk insured, including the following information:

6.2.1. planned dates of the beginning and end of the trip, number of days of stay in the insurance territory;

6.2.2. purpose of the trip; the Insured Person’s work and/or study nature, intensity and conditions if the Insured Person shovels off for a trip for employment or for study;

6.2.3. amateur sports activities or type of sports event in which the Insured Person is expected to participate, including training, as well as active recreational activities that the Insured Person intends to engage in;

6.2.4. age of the Insured Person;

6.2.5. state of health of the Insured Person, including the presence of chronic diseases, pregnancy;

6.2.6. address of registration in the territory of the Russian Federation, country for a foreign citizen;
6.2.7. in case of conclusion of the Insurance Contract on “Trip Cancellation” risk: if a trip is made through the tour operator/travel agent – date of payment of the Tourism Product Sale Agreement (in case of payment of the Tourism Product Sale Agreement in installments – date of payment of the first installment); if a trip is arranged by itself – date of payment of personal travel documents, date of payment for the hotel.

For the purposes of these Rules, the personal travel documents mean tickets for railway, air and water transport, unless otherwise expressly provided for in the Contract (Policy).

6.3. The Insurance Contract is concluded before the Insured Person’s departure outside the administrative boundary of the settlement that is his/her place of residence on the basis of an oral or written application of the Policyholder in which it provides information specified in cl. 6.2 required for the conclusion of the Contract and the assessment of the risk insured. Written application of the Policyholder must be submitted in the form of a completed insurance declaration as approved by the Insurer, unless otherwise provided by the Insurance Contract.

6.4. The Insurance Contract is concluded without medical examination of the Insured Person. At the request of the Insurer in special cases, the Insured (the Insured Person) must complete an application for insurance/a medical questionnaire and/or provide the relevant documents and/or undergo a medical examination. When applying for insurance for persons who have a disability group (category) or referral to medical and social expertise, completion of a medical questionnaire is mandatory (Annex No. 4 to these Insurance Rules). If the Policyholder (the Insured Person) refuses to comply with the requirements of this clause, the Insurer has the right to apply a corrective factor to the basic insurance rate and/or franchise for this Insured Person when concluding the Insurance Contract.

6.5. The Insurance Contract is concluded no more than 6 (six) months before the start date of the insurance period, unless otherwise provided by the Insurance Contract.

6.6. The Insurance Contract is concluded in writing and may be concluded:
   - by drawing up a full-text Insurance Contract signed by both parties. In this case, at the request of the Insured, an insurance Policy signed by the Insurer may be issued in support of the conclusion of the Insurance Contract;
   - by drawing up an insurance Policy signed by both Parties with the attachment of these Rules.

6.7. The terms and conditions contained in these Rules and not included in the text of the Insurance Contract (insurance Policy) are binding on the Parties if the Insurance Contract (insurance Policy) explicitly indicates the application of these Rules and the Rules are set out in the same document as the Contract (Policy) or on its reverse side, or are attached thereto.

6.8. During the term of the Contract, the Policyholder (the Insured Person) is obliged to ensure the safety of documents under the Insurance Contract. If the Insurance Contract (Policy) is lost or damaged before the expiry of the Insurance Contract, the Insurer issues a duplicate to the Policyholder on the basis of his/her written application. Data filled in by the Insurer in a duplicate must correspond to the data contained in the lost (damaged) Insurance Contract (Insurance Policy). After a duplicate is issued, the lost (damaged) Insurance Contract (Policy) is considered invalid and no insurance payments are made thereunder. If the Insurance Contract (Policy) is repeatedly lost (damaged), the Insurer has the right to demand, and the Policyholder is obliged to pay the cost of the form in the amount of 50 rubles.
6.9. When determining the amount of the insurance premium in the Insurance Contract using the notion “conditional unit” (clause 4.3.2.), payments under the Insurance Contract are made in rubles in the amount calculated based on the exchange rate of the relevant currency established by the Central Bank of the Russian Federation for that currency as of the date of conclusion of the Insurance Contract, unless otherwise provided by the Insurance Contract.

6.10. In order to confirm the accuracy of the information provided by the Policyholder, as well as for the purposes of identifying the Policyholder and the Insured Persons (Beneficiaries), the Insurer may request the following documents/data:

- a passport or other document proving the identity of the Insured Person;
- a migration card;
- a document confirming the right of a foreign citizen or stateless person to stay in the Russian Federation;
- a certificate of registration of an individual in the territorial body of the Federal Tax Service of Russia;
- a certificate of state registration of a legal entity;
- an extract from the unified state register of legal entities;
- a certificate of registration with the tax authority;
- a certificate of registration issued in the country of registration (for non-resident legal entities);
- a certificate of assignment of the code of a foreign entity issued in the country of registration (for non-resident legal entities);
- a certificate of registration of an individual as an individual entrepreneur;
- medical documents containing information about the state of health of the Insured Person (extracts from medical records containing information about seeking medical assistance and/or detailed data of his/her examination by medical specialists; certificates from dispensaries at the place of residence (psycho-neurological, narcological, oncologic, dermatologic and venereal diseases dispensary – is/is not registered), certificates of epidemiological surveillance institutions, results of medical research conducted for the Insured Person (electrocardiography, X-ray radiography or X-ray examination, computer studies, blood, urine tests, etc.), original medical documents and copies thereof;
- documents issued at the place of work/study of the Insured Person containing information on the nature, intensity and conditions of work and/or study (certificates, employment contracts, contracts, etc.);
- copies of Insurance Contracts previously concluded with regard to the Insured Person;
- notifications or orders of the state bodies of the Russian Federation to leave the territory of the Russian Federation;
- a statement of obligation completed and signed by the Insured Person to arrive at the airport/railway station at the planned time for the planned flight/rail run with the documents necessary for explaining/entraining.

All documents provided to the Insurer (with the exception of copies of the Insurance Contracts previously concluded with regard to the Insured Person) must be up-to-date and valid at the time of conclusion of the Insurance Contract or underwriting of the Insured Person.

In the event that the provided documents do not contain information prescribed by these Rules which is required for assessing the risk insured and underwriting of a specific person,
and also contain conflicting information, the Insurer has the right, upon agreement with the Policyholder, to request additional documents necessary for the conclusion of the Insurance Contract, to examine the provided documents, to check the information reported by the Policyholder (the Insured Person) in relation to the conclusion of the Insurance Contract by sending an official request to determine the possible amount of material damage. The Policyholder (the Insured Person) is obliged to provide the Insurer, at its request, with a written consent to obtain this information from medical and other institutions or to provide it on his/her own at the request of the Insurer.

In cases of the Policyholder’s refusal to provide additional documents requested, the Insurer has the right to apply a corrective factor to the basic insurance rate and/or franchise when underwriting a person for whom the documents requested by the Insurer have not been provided.

7. TERMINATION OF THE INSURANCE CONTRACT
7.1. The Insurance Contract terminates in the following cases:
7.1.1. upon expiry of the Insurance Contract;
7.1.2. upon fulfillment by the Insurer of the obligations to make the insurance payment in full before the expiry of the insurance period;
7.1.3. at the request of the Policyholder;
7.1.4. by agreement of the parties;
7.1.5. upon liquidation of the Insurer or revocation of its license;
7.1.6. upon failure to make the insurance premium (insurance contribution) – in accordance with the provisions of clause 7.6 of these Rules;
7.1.7. in other cases stipulated by the legislation of the Russian Federation.

7.2. In the event the Policyholder being an individual withdraws from the Insurance Contract within 5 (five) business days from the date of its conclusion in the absence of events bearing the signs of the event insured, the insurance premium paid is returned to the Policyholder within 10 (ten) business days:
   - in full amount upon withdrawal from the Contract before the start date of the insurance period;
   - with deduction by the Insurer of a part of the insurance premium proportional to the period of the insurance when withdrawing from the Contract after the start date of the insurance period.

The Insurance Contract terminates at 00 hours 01 minutes on the day of receipt by the Insurer of a written application of withdrawal therefrom from the Policyholder.

7.3. In the event of early termination of the Insurance Contract at the written request of the Policyholder, the latter must notify the Insurer in writing. The Insurance Contract is considered to be terminated from the moment of receipt by the Insurer of the application from the Policyholder, unless otherwise provided by the Agreement of the Parties or by the Application of the Policyholder.

7.4. If the Policyholder withdraws from the Insurance Contract provided that the insurance premium is paid in full under the Insurance Contract, unless otherwise provided by the Insurance Contract:
7.4.1. before the start date of the insurance period upon the expiry of 5 (five) business days from the date of conclusion of the Insurance Contract for all risks other than “Trip
Cancellation” risk, the insurance premium paid to the Insurer shall be returned to the Policyholder within 10 (ten) business days from the date of submission by the Policyholder of the application of termination of the Insurance Contract. In this case, the Insurer retains 40 (forty) percent of the insurance premium paid, but not less than 100 (one hundred) rubles.

7.4.2. after the start date of the insurance period upon the expiry of 5 (five) business days from the date of conclusion of the Insurance Contract for all risks, the insurance premium paid to the Insurer is not refundable.

7.5. With regard to “Trip Cancellation” risk upon the expiry of 5 (five) business days from the date of its conclusion during the term of the Insurance Contract, the insurance premium paid to the Insurer is not refundable.

7.6. For the purposes of these Rules, the Policyholder and the Insurer agree and acknowledge that failure to pay or payment by the Policyholder of a lesser amount of the insurance premium under the Insurance Contract that came into force within the time limits or in the amount provided by the Insurance Contract is unconditionally an expression of the will of the Policyholder/Beneficiary to unilaterally withdraw from the insurance contract (termination of the insurance contract) at 00 hours 00 minutes on the day following the date specified in the Insurance Contract as the date of payment of the insurance premium.

In this case, in the event of such withdrawal of the Policyholder/Beneficiary from the Insurance Contract due to failure to pay the insurance premium (insurance contribution) within the time limits specified in the Insurance Contract that came into force, or its payment in a lesser amount than provided for in the Insurance Contract, the Insurer shall notify the Policyholder on a consent to early termination on the initiative of the Policyholder (Beneficiary) of the Insurance Contract at 00 hours 00 minutes on the day following the date specified in the Insurance Contract as the last date of payment of the insurance premium (relevant insurance contribution) by sending to the Policyholder a written notice of termination of the Insurance Contract. In this case, the Insurance Contract is deemed to be terminated at 00 hours 00 minutes on the day following the date specified in the Insurance Contract as the date of payment of the insurance premium (relevant insurance contribution).

7.7. Upon termination of the Insurance Contract, the Insurer’s duty to make insurance payments in respect of events insured occurred after the termination of the Insurance Contract is terminated.

7.8. Upon termination of the Insurance Contract due to failure to pay the next insurance contribution, the insurance premium paid is not refundable.

8. GENERAL OBLIGATIONS AND RIGHTS OF THE PARTIES. RELATIONSHIPS OF THE PARTIES UPON OCCURRENCE OF THE EVENTS HAVING SIGNS OF AN EVENT INSURED

8.1. The Policyholder is obliged:
8.1.1. to notify the Insurer when concluding the Insurance Contract of:
8.1.1.1. circumstances known to the Policyholder that are essential to determine the probability of occurrence of an event insured and the amount of potential losses from its occurrence in accordance with clause 6.2 of these Rules;
8.1.1.2. at the request of the Insurer for legal entities – information on the loss ratio of the previous Insurance Contract;
8.1.2. to inform the Insurer during the term of the Insurance Contract about the significant changes that have become known to it in the circumstances notified to the Insurer when concluding the Insurance Contract, if these changes may significantly increase the risk insured. If the Policyholder has not notified the relevant information, the Insurer has the right to demand cancellation of the Insurance Contract and application of the consequences of the invalidity of the Contract provided for by the legislation of the Russian Federation;

8.1.3. to pay an insurance premium in the amount and within the time limits established by the Insurance Contract;

8.1.4. to provide the Insurer and its representative, at their request, with a written consent to obtain information from medical and other institutions, and to assist in obtaining it. When settling an event that has signs of an event insured, this obligation also applies to the Insured Person;

8.1.5. The Policyholder (the Insured Person, his/her representative) undertakes:

8.1.5.1. to be accessible for communication with the 24-hour assistance center of the Insurer using possible ways of communication;

8.1.5.2. to provide information requested by the 24-hour assistance center of the Insurer and documents necessary for settlement, including: copies of a passport, medical treatment documents, travel documents, documents of the competent authorities, written explanations.

In case of failure by the Policyholder (the Insured Person, his/her representative) to fulfill obligations provided for in clause 8.1 without objective reasons, the Insurer may refuse further organization of the settlement of an event that has signs of an event insured, or payment for an event insured, if failure to fulfill obligations entails:

- impossibility of establishing the circumstances of the declared event and/or unambiguous interpretation of the event as an event insured, confirmation or verification of the declared information;
- loss of a discount of a medical or transport establishment due to failure to fulfill the terms of payment priority;
- additional expenses incurred due to late payment of the invoice;
- unreasonable increase in the period of stay of the Insured Person in the insurance territory;
- placement of guarantee obligations for payment of expenses in the absence of sufficient information to recognize the event as insured.

If the Insurer has recognized the event as insured and payments have been made on it that subsequently have been recognized as not insured due to receipt of additional information not provided at the time when the decision to recognize the event involving the Insured Person as insured and to make the insurance payment has been taken, the Insurer has the right to demand the Insured Person to return the insurance payments.

8.2. The Insurer is obliged:

8.2.1. to inform the Policyholder (the Insured Person) in writing about the increase in the time for consideration of documents in order to take a decision on recognition/non-recognition of the event as an event insured (in the cases listed in clauses 8.5.5, 8.5.7 of the Rules);

8.2.2. to inform the Policyholder about the set of risks and exceptions under the Insurance Contract, to provide the Policyholder with the Insurance Rules. In addition, the Policyholder may read the Insurance Rules on the website www.rgs.ru.
8.3. The Policyholder has the right:
8.3.1. to receive a duplicate of the Insurance Contract in case of its loss, damage;
8.3.2. to early terminate the Insurance Contract.
8.4. The Insured Person has the right:
8.4.1. to receive services and reimbursement of expenses in accordance with the Insurance Contract;
8.4.2. to receive explanations from the Insurer under the Rules;
8.4.3. to inform the Insurer of the cases of failure to provide, incomplete provision or provision of substandard services under the Insurance Contract.

The Insured Person’s right to receive and pay for services, reimbursement of expenses stipulated in the Insurance Contract arises after the entry into force of the Insurance Contract.
8.5. The Insurer has the right:
8.5.1. to request information from the Policyholder on the circumstances that are of significant importance for determining the probability of occurrence of the event insured and the amount of potential losses from its occurrence when concluding the Insurance Contract;
8.5.2. to require the Policyholder and/or the Insured Person to complete an insurance application/medical questionnaire and/or to provide the necessary documents and/or to stand a medical examination;
8.5.3. to examine a person who is to be insured or received emergency services to assess the actual state of his/her health or the consequences of an event insured;
8.5.4. to check information provided by the Policyholder (the Insured Person);
8.5.5. to verify compliance by the Policyholder (the Insured Person) with the terms and conditions of the Insurance Contract;
8.5.6. if necessary to take a decision to make the insurance payment, to send inquiries to the competent authorities, official instances and institutions about the circumstances of the occurrence of an event insured and, if necessary, in consultation with the Policyholder (the Insured Person) to request from the Insured Person (Beneficiary, representative of the Insured Person) additional information and documents confirming the fact of occurrence and the cause of the event insured;
8.5.7. to demand the cancellation of the Insurance Contract and the application of the consequences provided by the current legislation of the Russian Federation if, after the conclusion of the Insurance Contract, it is established that the Policyholder has provided knowingly false information about circumstances that are of significant importance for determining the probability of occurrence of the event insured and the amount of potential losses from its occurrence;
8.5.8. to apply raising and/or lowering coefficients (hereinafter referred to as corrective factors) to basic insurance rates;
8.5.9. to check all submitted documents;
8.5.10. to conduct a medical examination of the Insured Person by a doctor appointed by the Insurer;
8.5.11. to recommend to the Policyholder (the Insured Person) through the Customer Service:
8.5.11.1. to independently apply to any of the official licensed medical institutions for medical assistance in emergency (urgent) order for vital indications with the involvement of local quick-care medicine;
8.5.11.2. to independently apply to any of the official licensed medical institutions for the necessary assistance for cash with preservation of all documents on an event that has signs of an event insured, and with subsequent application to the Insurer to take a decision on the issue of reimbursement of funds spent;

8.5.12. For the purposes of these Rules, the Service Company/Customer Service means a specialized service that, on behalf of the Insurer, provides the services provided by these Rules 24 hours a day, hereinafter referred to as the Customer Service.

8.6. Upon occurrence of the event that has signs of an event insured, the Policyholder (the Insured Person or his/her representative) is obliged:

8.6.1. the Insured Person, his/her representative or an interested person is obliged, in advance, at any time before applying to, visiting the medical institution, receiving/arranging for other services provided for in these Rules, to contact the 24-hour helpdesk of the Customer Service and to inform about the occurrence of an event that has signs of an event insured, at the telephone numbers specified in the Insurance Contract to enable the Customer Service to provide the necessary assistance in a timely manner, to issue the necessary recommendations, or to agree upon independent referral for the necessary assistance and the costs associated with it, and to inform/provide the following information:

8.6.1.1. surname, name of the Insured Person who needs assistance;
8.6.1.2. number of the Insurance Contract;
8.6.1.3. time and circumstances of the event occurred and the nature of the assistance required;
8.6.1.4. location of the Insured Person and the contact phone number for feedback;
8.6.1.5. in some cases, at the request of the Insurer or the Customer Service, to provide in any possible way a copy, scanned copy or photocopy of the Policy, the document of the reason for staying in the insurance territory;
8.6.1.6. a power of attorney in the name of the Insurer/Customer Service to represent interests for recovering from third parties the costs incurred by the Insurer in connection with the declared event. If the Policyholder (the Insured Person, his/her representative) refuses to provide such a power of attorney, the Insurer may refuse to pay all further expenses on the event on the basis of Article 965 of the Civil Code.

8.6.2. to provide the Insurer with all available and reliable information and documentation that allows to judge the causes and consequences of an event that has signs of an event insured, the nature and amount of damage caused. Provision of inconsistent, false or incomplete information entitles the Insurer to recognize the event as an event uninsured;

8.6.3. to follow all instructions of the Insurer or the Customer Service, including verbal instructions of the employee (contact person of the Customer Service), as well as the prescriptions and instructions of the attending physician in the insurance territory authorized by the Insurer or the Customer Service (hereinafter referred to as the attending physician). In case of failure to comply with this clause of the Rules, the Insurer shall be released from the subsequent obligations for that event insured;

8.6.4. to fulfill the duties stipulated in the Contract (Policy) and these Rules;

8.6.5. to release the attending physician and other medical personnel providing services to the Insured Person from the obligations of confidentiality to the Insurer/Customer Service with regard to the transfer of information relating to the event insured;
8.6.6. to give a consent to provide the Insurer/Customer Service with information on the state of his/her health;
8.6.7. to pass an examination to assess his/her actual state at the request of the Insurer/Customer Service;
8.6.8. to take reasonable and available measures in the circumstances to reduce potential losses, and to act as if the persons insured by it, his/her property and/or liability were not insured;
8.6.9. to receive medical and other assistance in accordance with the instructions of an employee of the 24-hour helpdesk of the Customer Service;
8.6.10. to present the original insurance Policy to medical personnel;
8.6.11. if the Insurance Contract provides for a franchise in monetary terms, to make an additional payment for the services rendered in the amount thereof at his/her own expense;
8.6.12. to comply with the prescriptions of the doctor and the procedure established by the medical institution;
8.6.13. if it is impossible to contact the 24-hour helpdesk upon occurrence of the event insured, to contact it at the earliest opportunity to register a referral in the database of the Customer Service through the an employee of the 24-hour help center and to resolve the possibility of organizing assistance in medical treatment facilities collaborating with the Customer Service. Not to pay for any services without the consent of the Customer Service;
8.6.14. to substantiate to the Insurer in writing the reason for not fulfilling the requirements of clause 8.6.
8.7. If the uncoordinated actions of the Insured Person/his/her representative have led to an increase in the Insurer’s expenses and/or a provision of unreasonably inflated accounts for reimbursement, the Insurer has the right to make insurance indemnity for the services rendered at a cost equal to the cost of similar services in case of timely referral and assistance through the Customer Service.
8.8. The Insurance Contract may provide for other rights and obligations of the Parties.

9. INSURANCE PAYMENT. PROCEDURE FOR DETERMINATION THE AMOUNT AND MAKING OF THE INSURANCE PAYMENTS. EXEMPTIONS FROM PAYMENT

9.1. Upon occurrence of an event insured, the Insurer is obliged to make an insurance payment in accordance with the procedure and on the terms determined by these Rules.

The insurance payment is a sum of money that is determined in accordance with the procedure established by the Insurance Contract and paid by the Insurer to the Policyholder (the Insured Person, the Beneficiary) upon occurrence of an event insured. The maximum amount of insurance payment for an individual risk may not exceed the amount of the sum insured for this risk.

9.2. Regarding the reimbursement of certain types of expenses the maximum amount of insurance payment (hereinafter – the liability limit) may be established in these Rules and/or directly in the Insurance Contract.

The amount of insurance payment may not exceed the corresponding liability limit of the Insurer. The total amount of payments may not exceed the amount of the total sum insured specified in the Insurance Contract (Rules).
9.3. The procedure for determining the amount and making of the insurance payment is defined for each risk in the relevant sections of these Rules.

9.4. The insurance payment to the Policyholder (the Insured Person, the Beneficiary) is made in rubles.

9.4.1. Reimbursement of expenses expressed in a currency other than the Russian ruble is made in rubles at the rate of the Central Bank of the Russian Federation for the currency:
   a) at the date of the event insured for “Medical and Emergency Assistance” risk;
   b) at the date of conclusion of the Insurance Contract for the event insured for the following risks: “Accident”, “Trip Cancellation”, “Luggage”, “Civil Liability”.

9.5. In order to resolve the issue of recognition of the event that involves the Insured Person as an event insured and insurance payment, the Policyholder (the Insured Person, the Beneficiary, heirs) is obliged to submit to the Insurer a written application with attached documents the full list of which is indicated in the relevant sections of these Rules for each risk.

9.6. The insurance payment is made in the amount of direct actual expenses (losses) reimbursable under the Insurance Contract, less the franchise, but not exceeding the sum insured and liability limits established in the Insurance Contract for this type of risk insured and/or expenses.

9.7. The deadline for the submission of a written application and the provision of original documents for obtaining an insurance payment is 30 (thirty) business days from the date of return from the trip. If the Insurance Contract (insurance Policy) provides for multiple trips, it means the return from the trip during which the event insured occurred.

9.8. Upon receipt by the Insurer of the documents necessary and sufficient to establish the fact, reasons, circumstances of the event insured and the amount of loss as specified in the relevant sections of these Rules for each risk, the Insurer within 7 (seven) calendar days takes a decision to recognize or not to recognize the declared event as an event insured. The Insurer has the right, at its discretion, to shorten the list of documents necessary and sufficient to establish the fact, reasons, circumstances of the event insured and the amount of loss as specified in the relevant sections of these Rules for each risk and to take a decision on the recognition of the event that involves the Insured Person as an event insured.

The insurance payment is made to a person entitled to receive it within 10 (ten) calendar days after the decision to recognize the declared event as an event insured is taken. In cases when the insurance payment is made to a person/entity that provided the service, the insurance payment is made within the time limits and in accordance with the procedure as agreed with the receiving entity.

After the insurance payment is made, the original documents are not returned to the Insured Person.

If a decision is taken to refuse an insurance payment, a written notice of the decision taken with a justification of the reasons for the refusal is sent to the Policyholder (the Insured Person) within 7 (seven) calendar days from the date of the decision on non-recognition of the declared event as an event insured.

9.9. After the insurance payment is made, the right to assert a claim (in the amount of the sum paid) to a person responsible for the damage, except for “Civil Liability” and “Accident” risks passes to the Insurer.
9.10. If the Policyholder (the Insured Person) has waived his/her claim to a person responsible for damages reimbursed by the Insurer, or the exercise of that right has become impossible due to the fault of the Policyholder (the Insured Person), the Insurer is released from the insurance payment in full or in the relevant part and has the right to demand the return of the overpaid insurance payment.

9.11. In the event that in the course of settlement of the declared event, it follows from the documents and materials received by the Insurer that:

9.11.1. this event is recognized as non-insured or not covered by the Insurance Contract concluded pursuant to these Rules, then in accordance with an additional agreement signed by both parties, the medical and other services paid for by the Insurer/Customer Service and already provided and/or to be provided to the Insured Person are to be reimbursed to the Insurer and/or Customer Service by the Insured Person and/or the Policyholder at the written request of the Insurer/Customer Service within 30 (thirty) calendar days from the end date of the Insured Person’s trip;

9.11.2. although this event is recognized as insured, but in accordance with the terms and conditions of the Insurance Contract and the additional agreement signed by both parties, the insurance indemnity is paid in the amount of the established limit (sum insured) for the relevant event, then the medical and other services paid for by the Insurer/Customer Service and already provided and/or to be provided to the Insured Person in excess of the established limit (sum insured) must be reimbursed to the Insurer/Customer Service by the Insured Person and/or the Policyholder at the written request of the Insurer/Customer Service within 30 (thirty) calendar days from the end date of the Insured Person’s trip.

9.12. The Insurer does not have legal grounds/obligations to pay an indemnity:

9.12.1. if a person requesting insurance payment is not a Policyholder, an Insured Person, an Beneficiary or a proxy of any of them;

9.12.2. if the Insurance Contract is invalid in accordance with the legislation of the Russian Federation;

9.12.3. if the declared event (loss) did not actually take place or is not confirmed by the relevant documents;

9.12.4. if the event occurred does not correspond to the signs of an event insured as provided for by these Rules and/or the Insurance Contract;

9.12.5. if the declared event occurred before the conclusion of the Insurance Contract;

9.12.6. if the event occurred and (or) losses are excluded from insurance in accordance with the terms of these Rules and/or the Insurance Contract;

9.12.7. if there are grounds for the Insurer to be released from the insurance payment in accordance with the legislation of the Russian Federation;

9.12.8. if any of the conditions provided for by one or more of the following sections 8, 9, 15, 16, 20, 21, 24, 31, 32, 36, 37 of these Rules has not been fulfilled, and this failure affected the Insurer’s obligation to pay insurance indemnity (Article 961 of the Civil Code);

9.12.9. regarding the insurance payment which is not documented by the Policyholder, the Insured Person (Beneficiary) and the absence of documents upon the occurrence of the declared event does not allow the Insurer to establish the appropriate amount/part of the losses;

9.12.10. if the loss is reimbursed by third parties;
9.12.11. if the Policyholder unilaterally refuses to perform the obligations and/or changes the terms of these Insurance Rules and/or the concluded Insurance Contract;
9.12.12. if the Policyholder (the Insured Person) does not timely notify the Insurer of the occurrence of an event that has signs of an event insured, in accordance with clause 8.6.1 of these Rules unless it is proved that the Insurer has timely learned about the occurrence of an event that has signs of an event insured or that the Insured Person for medical reasons could not contact the Customer Service/the Insurer upon occurrence of an event that has signs of an event insured.

10. PERSONAL DATA
10.1. The Policyholder who has concluded the Insurance Contract with the Insurer on the terms of these Insurance Rules confirms his/her consent to processing by the Insurer of the following personal data of the Policyholder for the purpose of insurance under the Insurance Contract, including for the purposes of checking the quality of rendering insurance services and settling losses under the Contract, administrating the Contract, and also in order to inform the Policyholder about other products and services of the Insurer.
10.2. Personal data of the Policyholder include: surname, name, patronymic, year, month, date and place of birth, passport data, address of residence, other data specified in the Insurance Contract concluded with the Insurer (including its integral parts – insurance application, annexes etc.) which may be attributed in accordance with the legislation of the Russian Federation to personal data.
10.3. The Policyholder provides the Insurer with the right to carry out all actions (operations) with personal data, including collection, systematization, accumulation, storage, clarification (updating, modification), use, depersonalization, blocking, destruction. The Insurer has the right to process personal data by including them in electronic databases of the Insurer.
10.4. The Insurer has the right, in fulfillment of its obligations under the Insurance Contract, to transfer the Policyholder’s personal data to third parties, provided that the Insurer has an agreement with the said third parties that ensures the safety of personal data during their processing and prevents the disclosure of personal data.
10.5. By confirming the receipt of these Insurance Rules, the Policyholder agrees to the processing of the Policyholder’s personal data upon conclusion of the Insurance Contract (if the Insurance Contract was preceded by the Policyholder’s insurance application, then the consent is valid from the date specified in the insurance application). The consent of the Policyholder to the processing of the Policyholder’s personal data is valid for 10 years (unless otherwise stipulated by the Insurance Contract).
10.6. The Policyholder has the right to withdraw his/her consent by drawing up a corresponding written document which must be sent to the Insurer by registered mail with a notice of delivery or handed personally against receipt to the authorized representative of the Insurer. If the Insurer receives from the Policyholder a written application for withdrawal of consent to the processing of personal data, the consent shall be deemed withdrawn from the date of receipt of this application by the Insurer. Upon expiry of the Insurance Contract (including in case of its termination) or withdrawal of consent to the processing of personal data, the Insurer undertakes to cease processing personal data and to destroy the personal
data of the Policyholder within a period not exceeding 10 years after the expiry date of the
Insurance Contract/withdrawal of consent to the processing of personal data.

10.7. The Policyholder has the right not to provide the Insurer with the right to use the
above personal data. The Policyholder may also at any time limit or withdraw the consent
given to the processing of personal data.

10.8. In case of disagreement of the Insured to provide the above personal data, the
Insurer, if there is a need to process personal data, requests the consent of the Policyholder in
accordance with the current legislation.

10.9. The Insurer hereby also confirms that the absence of the Policyholder’s consent to
the processing by the Insurer of personal data in no way affects the rights of the Policyholder
and/or the Insurer’s obligations under the concluded Insurance Contract.

10.10. The above provisions of this clause of the Insurance Rules also apply to the
Beneficiary/the Insured Person in the event that he/she signs a consent to the processing by
the Insurer of personal data.

11. SETTLEMENT OF DISPUTES

11.1. Disputes arising under the Insurance Contract are settled through negotiations.

11.2. If the agreement is not reached, the dispute shall be referred to the court in the
manner prescribed by the legislation of the Russian Federation. The rights and obligations of
the parties under the Insurance Contract concluded on the basis of these Rules are regulated
by the legislation of the Russian Federation.
SECTION 2. INSURANCE FOR “MEDICAL AND EMERGENCY ASSISTANCE” RISK

12. INSURED PROPERTY
The property insured is the property interests of the Insured Person related to the payment of the organization and provision of medical and medicinal assistance (medical services), other services to the Insured Person due to a disorder in the state of health of the Insured Person that requires the organization and provision of such services.

13. CASES INSURED AND EXPENSES REIMBURSABLE BY THE INSURER
13.1. The event insured for the risk of insurance “Medical and Emergency Assistance”, unless otherwise provided by the Insurance Contract, is an event arisen in the insurance territory within the time limits specified by the Contract and required the Policyholder (the Insured Person, his/her representatives) to seek in the insurance territory within the time limits indicated by the Contract:

13.1.1. medical assistance and medical services that must be provided because of the contraction of a sudden acute illness confirmed by instrumental or laboratory diagnostic methods and the objective symptoms established by the doctor that threatens the life of the Insured Person or the occurrence of the consequences of an accident in the form of a health disorder.

Hereinafter, medical assistance is understood as emergency medical assistance provided in case of sudden acute illnesses, conditions, exacerbation of chronic diseases that endanger the life of the Insured Person within the insurance period specified in the Contract and in the insurance territory.

Hereinafter, a sudden acute illness is understood as a health disorder of the Insured Person (not related to previous health disorders (chronic or relapsing)) diagnosed for the first time in the insurance territory during the insurance period specified in the Contract, which diagnosis was made in the same period on the basis of objective symptoms known to the medical profession and requires urgent treatment.

Hereinafter, an accident is understood as a sudden, unforeseen, unintended, short-term external event or impact, the nature, time and place of which may be uniquely identified and which entailed bodily injury or other impairment of the body’s functions or death of the Insured Person, not as a consequence of the disease, occurred during the insurance period specified in the Contract and in the insurance territory, regardless of the will of the Insured Person and/or the Policyholder and/or the Beneficiary;

13.1.2. organization of medical transport/transport services in accordance with the procedure established by the Insurance Contract and/or the Rules;

13.1.3. organization of repatriation of a deceased body of the Insured Person or a funeral urn of the Insured Person whose death occurred as a result of an event insured;

13.1.4. organization of emergency assistance related to the provision of medical, medical transport services and other services provided for in the Insurance Contract, provided that application of the Policyholder (the Insured Person) in accordance with clauses 13.1.1 – 13.1.4:

13.1.1) does not concern:
a) a disease or an accident that does not require emergency medical care or interfere with the continuation of the trip and the stay of the Insured Person in the insurance territory or the treatment of which may be carried out upon the return of the Insured Person to the place of residence;

b) a chronic and relapsing disease, its exacerbation or complication, as well as a disease that existed before the start date of the insurance period or started before arrival to the insurance territory. If the exacerbation or complication of a chronic illness causes a state that threatens the life of the Insured Person, the limit of insurance indemnity/expenses paid by the Insurer amounts to 5 (five) percent of the sum insured specified in the Contract per Insured Person for the entire insurance period, unless otherwise stipulated by the terms and conditions of the Insurance Contract, with the exception of the Insurance Contracts with the condition “Chronic Disease” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.4 of these Rules;

c) a disease or a health disorder due to non-fulfillment or improper fulfillment of prescriptions of the attending physician, as well as due to self-treatment and/or taking medications not prescribed by that doctor;

d) skin diseases: fungoid diseases, psoriasis, dermatitis (including allergic), ingrown nail, calluses, as well as sunburn and other skin diseases and diseases of subcutaneous fat associated with exposure to sunlight;

e) a disease included in the class “Diseases of the endocrine system, eating disorders and metabolic disorders E00-E90” of the International Statistical Classification of Diseases and Related Health Problems, the 10th revision adopted by Order No. 170 dated 27.07.1997 of the Ministry of Health of the Russian Federation (hereinafter – ICD-10), and also their consequences and complications;

f) a disease included in the block “Abundant, frequent and irregular menstruation, other abnormal bleeding from the uterus and vagina, menopausal disorders and other abnormalities in the perimenopausal period N92” of the ICD-10, and also violations of the ovulatory menstrual cycle;

g) a disease and a condition requiring cosmetic or plastic surgery;

h) diseases included in the class “Mental and behavioral disorders F00-F99”, and blocks “Demyelinating diseases, central nervous system diseases G35-G37” and “Episodic and paroxysmal disorders G40-G47” of the ICD-10;

i) a disease included in section “Lesion of intervertebral discs M 51.0 – M 51.9, G 55.1” of the ICD-10;

j) infections with a predominantly sexual mode of transmission; HIV infection, mycoses, candidiasis, viral hepatitis (except for hepatitis A and E), infections caused by the herpes virus;

k) an injury got by the Insured Person when using motor vehicles (motorcycles, jet skis, motor scooters, mopeds, motorbikes, scooters, quads, all-terrain vehicles, snowmobiles, segways, go-carting, rafting), regardless of whether the Policyholder (the Insured Person) was a driver or passenger, with the exception of the Insurance Contracts with the condition “Sports” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.1 of these Rules;

l) an injury got during driving by the Insured Person of a vehicle without a legal basis for driving, including the absence of a license to drive a vehicle of the appropriate category;
m) an injury of the Insured Person got during flight on any type of aircraft (non-motorized, motor gliders, paragliders, ultralight vehicles, etc.), operating it, except in cases of flight as a passenger on a civil aviation aircraft of a conventional or charter flight operated by a professional pilot;

n) an injury got during the Insured Person’s going in for any kind of sport and participation in training and sporting events, participation in competitions of athletes on a professional or amateur level, and also any active rest, except for the Insurance Contracts with the condition “Sports” reflected in the column “Special Conditions” of the Policy according to clause 3.4.1 of these Rules;

o) an injury got during climbing, mountaineering, ice climbing, heli-skiing, paragliding; an injury got during diving for depth of more than 40 meters and/or using gas mixtures in which the oxygen content differs from 21 (twenty-one) per cent and/or without the certificate of the scuba diver association, regardless of whether the Contract (Policy) includes the condition “Sports” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.1 of these Rules;

p) an injury or a state sustained during the Insured Person’s engagement in any type of work activity, including but not limited to, during any work that increases the probability of injury, both in professional and non-professional activities, with the exception of the Insurance Contracts with condition “Profession” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.3 of these Rules;

q) an injury or a state sustained during the performance by the Insured Person of any type of professional work not provided for under the conditions of his/her employment contract (agreement) caused by the fault of the employer of the Insured Person;

r) an injury, a disease sustained during the period of service of the Policyholder in the armed forces of any state and any formations;

s) a state associated with congenital anomalies (development diseases), deformities and chromosomal abnormalities identified in a separate class of diseases Q00-Q99 of the ICD-10;

t) a state of pregnancy and its complications, as well as all related medical, obstetrical and other procedures, with the exception of the Insurance Contracts with the condition “Pregnancy” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.5 of these Rules. In any case, the Insurer does not reimburse expenses incurred in connection with the management, treatment, transportation, evacuation and repatriation of a newborn child of the Insured Person;

u) any event associated with providing care for cancer and benign neoplasms, including hemoblastoses, their complications and consequences, including death;

v) any event if the Insured Person has intentionally and knowingly:
   - caused damage to his/her health, undertook suicide attempts and other deliberate actions aimed at the occurrence of an event insured, except for cases when the Policyholder was brought to such a state by illegal actions of third parties as confirmed by decisions of the relevant bodies;
   - deliberately subjected his/her life and health to unjustified/increased risk, except for cases of saving a life for another person, by disregarding safety rules as confirmed by the documents of the relevant authorities;
w) any event that occurred while the Insured Person was in a state of alcoholic intoxication (including offenses, accidents that occurred during the Insured Person’s driving of any vehicle);

x) any event occurred while the Insured Person was influenced by narcotic or other intoxicating substances (including offenses, accidents that occurred during the Insured Person’s driving of any vehicle);

y) the occurrence of force majeure, such as war, military actions, as well as maneuvers or other military measures and their consequences, strikes, revolutions, insurrections, civil unrest, public disturbance of all kinds and riots; natural disasters and their consequences, epidemics, meteorological conditions, nuclear explosion, direct or indirect effects of radiation, radioactive or other types of infection, any types of emergency situations (catastrophes, etc.), and other force majeure circumstances, as well as cases provided for by the legislation of the Russian Federation;

z) acts of terrorism and their consequences;

aa) realization by the Insured Person of a trip with the intention to receive treatment or when a trip was contraindicated to the Insured for health reasons according to the certificate of a medical organization, regardless of whether the declared event is related to this treatment or not;

13.1.2) is not related to reimbursement of expenses, even if there are medical indications for their occurrence regarding/in the case of:

a) caring for the Insured Person by close relatives and any persons not agreed with the Customer Service or the Insurer;

b) treatment which based on the time for administering may be provided after the return of the Insured Person to the place of residence, as well as expenses related to the provision of services that are not necessary from a medical point of view or with treatment not prescribed by a doctor;

c) treatment on vacation, sanatorium, therapeutic or custodial care, rehabilitation, restorative treatment, aftercare, physical therapy, as well as expenses related to the provision of additional comfort, namely: a luxury ward, TV, telephone, air conditioner, humidifier, services of a hairdresser, a masseur, a cosmetologist, an interpreter (if the services of an interpreter are not provided for in the Insurance Contract), etc.;

d) treatment of diseases included in the class “Mental and behavioral disorders (F00-F99)”, and blocks “Demyelinating diseases of the central nervous system G35-G37” and “Episodic and paroxysmal disorders G40-G47” of the ICD-10;

e) treatment, deterioration of the state of health or death of the Insured Person as a result of diseases treated within 6 months preceding the trip, unless the Insured Person has received and submitted to the Insurer a written certificate of a doctor about the absence of contraindications for the trip on the date of conclusion of the Contract (Policy);

f) treatment, deterioration of the state of health or death of the Insured Person if the trip was contraindicated to the Insured Person by the attending physician for health reasons;

g) treatment during a trip which was recommended or prescribed to the Insured Person before the trip;

h) provision of a planned treatment, even if these activities are related to the occurred event insured;
i) payment of cosmetic treatment and/or procedures, hydrotherapy and non-traditional methods of treatment;

j) operations on the heart and vessels, angioplasty, coronary angiography, stenting, shunting, angiography, expenses for the purchase of metal structures for the operation of osteosynthesis; arthroscopic treatment;

k) implantation and reimplantation of organs and tissues;

l) diagnosing and treating sulfuric plugs;

m) diagnostic studies as a result of which no sudden acute illness was detected, the consequences of an accident endangering the life of the Insured Person were not revealed;

n) purchase of medicines and any drugs not prescribed by the attending physician in the insurance territory; purchase of any medical equipment;

o) medical, medical and transport expenses, including repatriation, for the treatment that is the purpose of the trip, as well as expenses caused by the deterioration of the state of health or death of the Insured Person occurred during a trip aimed at a receipt of treatment and/or rehabilitation;

p) transport services not confirmed by the relevant documents (account, receipt, check);

q) any preventive measures, examinations, general medical examinations, any kind of vaccination;

r) any prosthetics, endoprosthetics, dental and eye prosthetics, as well as purchase of medical equipment;

s) judicial and extrajudicial costs of the Insured Person, such as payment for notary services, payment of state duty and other mandatory fees, payment of fines, awarded (imposed by the authorized body) monetary penalties;

t) events taken place after the return of the Insured Person from the insurance territory, as well as after termination of the Insurance Contract;

u) for moral damage;

v) if the Insured Person receives damages from other persons, including the Insurance Companies and those responsible;

w) infectious diseases that present a danger to others: HIV infection, leprosy, tuberculosis, infections with a predominantly sexual mode of transmission;

13.1.3) is not accompanied by:

a) violation by the Insured Person of the rules for the prevention of diseases, as well as failure to comply with the prescriptions of a doctor;

b) refusal of the Insured Person (his/her representative) as from the date of refusal:

- from the fulfillment of prescriptions of the attending physician received by him/she in connection with the application concerning the event insured;

- from evacuation to the transportation connection point (airport, railway station, port) of the city where the Insured Person permanently resides;

- from the organization of transfer to another medical institution proposed by the Customer Service.

The refusal of the Insured Person to sign a statement of refusal of the services offered by the attending physician and/or the Service Department and/or the Insurer does not entail an obligation to make an insurance payment for the Insurer;
13.2. Under these Rules, the Insurer, in accordance with the Insurance Contract, reimburses the costs associated with the organization and provision of the services specified in this section, unless otherwise stipulated in the Insurance Contract:

- by the Customer Service which organizes and provides the services specified in this section;
- directly to the Insured Person if his/her expenses were previously agreed with the Customer Service or the Insurer upon provision of documents on incurrence of appropriate expenses related to the event insured.

At the same time, the Insurer is not responsible for the quality of services rendered by third parties (medical institutions, transport companies, etc.)

13.3. The expenses to be reimbursed provided that the event is recognized as an event insured, for “Medical and Emergency Assistance” risk, unless otherwise provided by the Insurance Contract, include:

13.3.1. medical expenses:

13.3.1.1. medical expenses on outpatient treatment:
   a) for medical services prescribed by the attending physician;
   b) for diagnostic studies;
   c) for medicines;
   d) for dressings and means of fixation (gypsum, bandage).
   e) if, at the time of the doctor’s visit organized by the Customer Service, the Insured Person is absent from the place of call or does not appear at the reception, the next visit of the doctor and his/her services are organized and paid for by the Insured Person. In this case, the Customer Service provides the coordinates of the medical institution for independent referral of the Insured Person or call of the doctor at the place of stay. The Insured Person at the request of the Insurer is obliged to reimburse the costs that were incurred to organize a visit that did not take place in this situation;

13.3.1.2. medical expenses for stay and treatment in a 24-hour in-patient hospital agreed by the Insurer and/or the Customer Service:
   a) for a standard ward, unless otherwise specified in the Contract;
   b) for medical services;
   c) for conducting operations;
   d) for urgent diagnostic studies;
   e) for payment of medicines prescribed by the attending physician;
   f) for dressings and means of fixation (gypsum, bandage).

   In the presence of objective circumstances that prevent the approval of hospitalization at the time of occurrence of an event that has signs of an event insured, the Insured Person himself/herself or his/her representative must agree with the Insurer and/or the Customer Service on such expenses at the earliest opportunity by before the Insured Person’s returning from the trip to the place of residence;

13.3.1.3. medical expenses for emergency dental solutions (in the amount not exceeding 1 (one) percent of the sum insured per Insured Person for the entire insurance period, unless otherwise provided by the Insurance Contract):
   a) for dental examination, removal or plugging of teeth as a result of acute tooth disease and/or teeth surrounding tissue or injuries resulting from an accident;
   b) for X-ray examination;
13.3.1.4. medical expenses for health observation in a 24-hour in-patient hospital of the Policyholder (the Insured Person). It is organized only by the Customer Service.

13.3.2. medical and transport expenses:

13.3.2.1. transportation by the ambulance (including emergency and urgent assistance by the emergency team) or other means of transport agreed upon with the Insurer/Customer Service to a doctor in the immediate vicinity or a medical institution in the insurance territory if medical transportation is necessary for life indications in the insurance territory, as well as when the Insured Person is unable to move independently;

13.3.2.1.1. costs of medical transportation are also paid if it was carried out by the ambulance to save the life of the Insured Person in a situation where the Insured Person’s state of health did not allow him/her to contact the Customer Service in advance;

13.3.2.1.2. the Insurer’s liability limit for any costs associated with the organization and conduct of evacuation from remote or hard-to-reach places requiring the use of air transport (in the mountains, at sea, in the desert or other areas) is, for the Insured Person under the Contract, the equivalent of not more than 8 (eight) percent of the sum insured, unless the Insurance Contract provides for another liability limit or other conditions;

13.3.2.2. emergency medical transportation to the transportation connection point (airport, railway station, port) of the city where the Insured Person permanently resides by the most economical mode of transport provided that there is no possibility in the territory of insurance to provide the required medical assistance;

13.3.2.3. emergency medical transportation by the most economical mode of transport, including the costs of accompanying by medical personnel as prescribed by the attending physician and the doctor of the Customer Service for performing medical manipulations during transportation to the transportation connection point (airport, railway station, port) of the city where the Insured Person permanently resides, provided that there is no possibility for the Insured Person to return to the place of residence on his/her own due to an event insured. Medical transportation is carried out only in the absence of medical contraindications; in this case

a) medical transportation of the Insured foreign citizen or stateless person to the nearest international transportation connection point of the country of permanent residence of the Insured Person is carried out only upon payment of an additional insurance premium as reflected in the column “Special Conditions” of the Policy. Otherwise, medical transportation is carried out to the place of conclusion of the Insurance Contract, unless otherwise stipulated in the Insurance Contract;

b) any emergency medical transportation is carried out exclusively by the Customer Service or by agreement with it and only in cases when its necessity is confirmed by the certificate of the attending physician, the expert doctor of the Insurer and the doctor of the Customer Service on the basis of the documents received from the attending physician and provided there are no medical contraindications, and also with the consent of the Insured Person (his/her representatives) for transportation;

c) if it is impossible for medical reasons to use travel documents, the Policyholder and the Insured Person are obliged to take reasonable and available measures in the circumstances to reduce potential losses, including:

- to return (repay) and refund their value. In case of non-observance of this condition, the Insurer is entitled to deduct from the amount of reimbursement of the Insured Person’s
expenses for returning to the place of permanent residence the value of unused travel
documents;
  - to exchange for travel documents with a later date for return to the place of permanent
residence. At the same time, the Insurer pays for the difference between the new travel
documents and the unused ones;
  d) all decisions on medical evacuation are taken by agreement of the attending physician
with the Insurer. At the same time, the Insurer does not bear liability in case the carrier does
not comply with the timetable.

13.3.3. expenses for the repatriation of a deceased body or a funeral urn of the Insured
Person (to be organized only by the Customer Service):
  13.3.3.1. whose death occurred as a result of an acute illness or accident during the
insurance period in the insurance territory, and payment of expenses agreed upon by the
Service and Insurer for the post-mortem examination and embalming of the body, the body
stay in the morgue, the purchase of a coffin required for the carriage of the body, the
necessary documents for transportation of the body to the transportation connection point
(airport, railway station, port) of the city where the Insured Person permanently resided. At
the same time, the Insurer does not pay for the funeral expenses, burial;
  13.3.3.2. in agreement with the relatives of a deceased Insured Person, repatriation of a
deceased body may be replaced by cremation in the insurance territory and transportation of
a funeral urn to the transportation connection point (airport, railway station, port) of the city
where the Insured Person permanently resided;
  13.3.3.3. repatriation of a deceased body/a funeral urn of the Insured foreign citizen or
stateless person to the nearest international transportation connection point of the country of
permanent residence of the Insured Person is carried out only if the additional insurance
premium is paid as reflected in the column “Special Conditions” of the Policy. Otherwise,
medical repatriation is carried out to the place of conclusion of the Insurance Contract or to
the transportation connection point nearest to the place of residence;
  13.3.3.4. repatriation may be carried out by a representative of the Insured Person,
provided all expenses for repatriation are coordinated with the Customer Service.

13.3.4. expenses for the organization of emergency assistance provided for in the
Insurance Contract, namely:
  13.3.4.1. expenses for the one way travel of the Insured Person by the economy class by
an airplane or other most economical mode of transport agreed with the Insurer, unless
otherwise stipulated in the Insurance Contract, to the transportation connection point (airport,
railway station, port) of the city where the Insured Person permanently resides. Those
expenses are reimbursed in case the departure of the Insured Person did not take place on
time, i.e. on the day specified in the travel documents held by the Insured Person, provided
that:
    a) the Insured Person stayed for 24 hours inpatient treatment for more than one day;
    b) the Insured Person had medical contraindications to the flight;
  13.3.4.2. expenses for the one way travel of one person who has an Insurance Contract
under these Rules and who was on the same trip with the Insured Person with whom the
event insured occurred and who is transported as described in clause 13.3.2.3, by the
economy class by an airplane or other most economical mode of transport agreed with the
Insurer, unless otherwise stipulated in the Insurance Contract, to the transportation
connection point (airport, railway station, port) of the city where the Insured Person permanently resides;

13.3.4.3. living expenses before departure:
   a) the costs of paying for the stay of the Policyholder (the Insured Person) in the hotel from the moment of his/her discharge from the 24-hour inpatient facility until the time of his/her departure to the place of residence, but not more than 2 (two) calendar days, based on the cost of living in a single room in a hotel of a category not higher than “three stars” and no more than the equivalent of 4,000 (four thousand) rubles per day or other limit for such expenses specifically established in the Insurance Contract;
   b) accommodation is organized by the Insured Person personally, but only in consultation with the Customer Service;

13.3.4.4. expenses for a third party visit:
   a) the cost of a ticket for one adult close relative to the place of 24-hour inpatient treatment of the Insured Person traveling without close relatives or with minor children, if the health of the Insured Person is assessed by the attending physician and the medical representative of the Customer Service as critical, life-threatening and the period of stay in a special care ward exceeds 7 (seven) calendar days unless otherwise provided by the Insurance Contract.

   A ticket is paid for the most economical mode of transport (“a roundtrip ticket”) agreed with the Insurer to the transportation connection point (airport, railway station, port) of the city to the place of 24-hour inpatient treatment of the Insured Person.

   A visit is organized by the Insured Person or his/her close relatives or authorized representatives independently, but only in consultation with the Customer Service. The Insurer reimburses the expenses for tickets required for the transportation specified in this clause only after the submission of documents confirming the degree of kinship and medical report;
   b) expenses for a visit of close relatives to foreign citizens or stateless persons from abroad are reimbursed only if the additional insurance premium is paid, as reflected in the column “Special Conditions” of the Policy.

   Any other costs, including the costs of transporting a third party from the transportation connection point and/or third-party accommodation costs are not covered for this risk;

13.3.4.5. expenses for the return of minor children (only if a minor child has a power of attorney from the parents for such transportation):
   a) expenses for transportation of minor children of the Insured Person who remain in the insurance territory without supervision as a result of an event insured that involves the Insured Person, to the transportation connection point (airport, railway station, port) of the city where they live.

   Transportation by economy class by an airplane or other most economical mode of transport agreed with the Insurer is paid, unless otherwise provided by the Insurance Contract, if necessary with an accompanying person provided by the carrier or the Customer Service;
   b) return of minor children of the Insured foreign citizen or stateless person outside the Russian Federation is carried out only if the additional insurance premium is paid as reflected in the column “Special Conditions” of the Policy, and if a child has an identity document and documents that allow him/her to cross the border of the Russian Federation alone.
Otherwise, the cost of returning only to the transportation connection point (airport, railway station, port) of the city where the minor children permanently reside in the territory of the Russian Federation, or to the place of conclusion of the Contract (the Policy) is paid.

For the purposes of these Rules, minor children are understood as minor children of the Insured Person (natural and adopted children under 14 years of age) legally accompanied by the Insured Person from their place of residence and left unattended as a result of the event insured that involves the Insured Person;

13.3.4.6. expenses for payment of emergency communications in the event of hospitalization of the Insured Person in the territory of insurance;

13.3.4.7. expenses for early repayment:
- expenses for transportation of the close relatives of the Insured Person who are with him/she in the territory of insurance, if in the event of an accident (road accident) they may not use the originally provided method of return within the initially established time limits due to injury or death of the Insured Person in the most economical way up to transportation connection point (airport, railway station, port) of the city where the close relatives of the Insured Person permanently reside. Transportation is organized by close relatives only by agreement with the Customer Service. The Insurer reimburses the expenses for the tickets required for that transportation;

13.3.4.8. expenses of the Insured Person for phone calls to the Customer Service are reimbursed provided that the event is recognized as an event insured, upon presenting supporting documents in an amount not exceeding the equivalent of 0.1 (zero point one) percent of the sum insured for each event insured, unless otherwise provided by the Insurance Contract. In this case, the invoice for the call should contain the following data: the date of the call, the telephone number, the duration of the negotiations and the amount paid as confirmed by documents;

13.3.4.9. expenses for obtaining legal aid:
   a) if necessary, unless otherwise specified in the Insurance Contract, the Insurer reimburses the costs of paying the initial legal advice rendered to the Insured Person in an amount not exceeding 10,000 (ten thousand) rubles for the whole insurance period, if the latter is pursued in a judicial order in connection with unintentional infliction of damage to a third party by the Insured Person, unintentional violation of normative acts, except for cases related to tax legislation, labor legislation, intentional violation by the Insured Person of the applicable legislation of the Russian Federation, the established and generally accepted rules and norms of behavior during the trip of the Insured Person, except for damages and violations associated with the use, possession and storage of vehicles;

13.3.4.10. administrative support costs:
   a) in the event of a theft or loss of the passport, the driver’s license of the Insured Person, travel documents, the Insurer pays the documented costs of finding and registering duplicates of lost documents/extracting duplicate documents of the Insured Person within a limit of not more than 3 (three) percent of the sum insured and not more than the amount of the original price (travel documents) for the whole period of insurance;
   b) in case of a theft or loss of luggage officially handed over to the carrier for transportation, the Insurer pays the documented costs of finding luggage within the limit of not more than 2 (two) percent of the sum insured;
13.3.4.11. costs of organizing and conducting search and rescue operations in the absence of any contact with the Insured Person and the impossibility to determine his/her exact location are carried out only by the Customer Service and only if the actions taken by the Insured Person (be it immersion, climbing, etc.) consequences of which require to carry out these works were formally properly registered in the insurance territory, were carried out using the proper equipment and fittings, via the declared route and a place of rest, if necessary and with a licensed instructor, and also subject to application of the corrective factors established by the Insurer to the basic insurance premium for “Medical and Emergency Assistance” risk when executing the Insurance Contract as reflected in the column “Special Conditions” by checking a special condition “Sports” according to clause 3.4.1 of these Rules;

13.3.4.11.1 the limit of the Insurer’s liability for any costs associated with the organization and conduct of search and rescue operations in remote or inaccessible areas requiring the involvement of air transport (in the mountains, the sea, in the desert or other areas) for the Insured Person for the entire insurance period is equivalent to not more than 30 (thirty) percent of the sum insured, unless the Insurance Contract provides for another limit or other conditions.

13.4. The parties may provide in the Insurance Contract that exceptions to insurance specified in clause 13.1 paragraphs 1) a)-aa), 2) a)-y), 3) a), b) are included in the insurance (the Insurer pays an insurance indemnity under the above circumstances), provided that the Insurance Contract (the Policy) in the column “Special Conditions” specifies paragraphs included in the insurance.

14. SUM INSURED. INSURER’S LIABILITY LIMITS
14.1. The sum insured under the Insurance Contract concluded against the possibility of events stipulated by Section 2 of these Rules is established by the agreement of the Policyholder with the Insurer and is specified in the Insurance Contract.

14.2. In the Insurance Contract, by agreement of the parties, liability limits for the expenses specified in clause 13.3 of these Rules, and a list of expenses to be reimbursed for “Medical and Emergency Assistance” risk may be established.

15. OBLIGATIONS OF THE PARTIES UPON OCCURRENCE OF THE EVENT INSURED
15.1. The Insured Person upon occurrence of events provided for in clause 13.1 of these Rules is obliged:
15.1.1. to perform the general duties provided for in clause 8.6 of these Rules;
15.1.2. in advance, at any time before the referral/visit to a medical institution or as soon as it becomes possible to notify the Insurer using the contact details (telephone numbers, e-mail) indicated in the Insurance Contract about the incident in order to enable the Insurer and/or the Customer Service to organize the necessary assistance in time or to agree on the independent referral for the necessary assistance and the costs associated with it, and to provide information in accordance with clause 8.6;
15.1.3. to receive medical assistance in strict accordance with the instructions of the Insurer’s employee;
15.1.4. to present the original Insurance Contract (Policy) to medical personnel;
15.1.5. to pay the franchise in the appropriate amount, if it is provided by the Insurance Contract (the Policy), to a medical institution that provided services on the event insured, and if it is impossible – to the Insurer upon return, in the appropriate amount, if it is stipulated in the Insurance Contract (the Policy);

15.1.6. to coordinate his/her actions with and to follow the instructions of the Insurer’s employee.

15.1.7. to comply with the prescriptions of the attending physician and the procedure established by a medical institution;

15.1.8. if it is impossible to contact the Customer Service and/or the Insurer upon occurrence of an event insured, prior to consulting a doctor or referring to a clinic, to do so at the earliest opportunity and to present the insurance Policy at the medical institution without paying for the services offered or rendered by third parties until receipt of an official confirmation of the possibility of payment for medical services from the Customer Service’s employee who registered that referral in the database of the Customer Service.

15.2. The Insurer is not liable to reimburse expenses specified in Section 2 of these Rules if the Policyholder (the Insured Person) has not performed or improperly performed the duties provided by these Rules, as a result of which the Insurer is unable to make an informed decision on recognition or non-recognition of the event as an event insured.

15.3. The Insurer is obliged:

15.3.1. to notify the Policyholder of its contact phone number and/or a 24-hour emergency telephone number;

15.3.2. if the event is recognized as non-insured, to inform within 20 (twenty) calendar days from the date of the decision the Policyholder (the Insured Person) of its decision in writing with a reasoned justification of the reasons.

16. PROCEDURE FOR MAKING INSURANCE PAYMENTS

16.1. The insurance payment is made if:

16.1.1. the Insured Person has received medical/medical and transport assistance organized and/or agreed upon by the Insurer;

16.1.2. the Insured Person has independently paid invoices for medical/medical and transport assistance/emergency assistance rendered to him/she as agreed with the Customer Service. When providing unpaid invoices, the Insured Person must provide written explanations. Unpaid invoices received by mail must be provided to the Insurer or the Customer Service within 10 (ten) calendar days from the date of receipt of the invoice. The Insurer, if the event is recognized as an event insured, reimburses the indicated expenses (or pays the account) on the basis of a written application of the Policyholder (the Insured Person/other authorized person) and original documents.

16.2. The application for insurance payment with a detailed description of the circumstances of the occurrence of the event and the amount of paid expenses must be accompanied by the originals or copies of documents certified by a notary or in accordance with the procedure established by the Law (payment documents – originals only):

16.2.1. the Insurance Contract;

16.2.2. Medical documents containing the address and contact details of a medical institution and a doctor, information about the date of seeking medical assistance, the state of health of the Insured Person at the time of seeking medical assistance, a diagnosis, medical
procedures and medications with a breakdown by date and cost, medical documents about
the accident; the result of a test or examination for alcohol in the event of an injury or an
accident (if any); a certificate of incapacity for work (if any), a driving license (if any);
16.2.3. official documents from the competent authorities (certificates of law
enforcement and judicial bodies) confirming the fact of an accident (an accident report) and
the circumstances of the incident;
16.2.4. documents confirming the fact of payment of medical services with indication of
the amount, currency, date and method of payment;
16.2.5. pharmacy checks/invoices for payment of medicines issued by the attending
physician in connection with the proven diagnosis and a prescription of the doctor with
indication thereof in the invoice/medical report;
16.2.6. documents confirming the fact of payment of telephone conversations (facsimile
communication) with the Insurer or the Customer Service or their representatives by phone
numbers specified in the Insurance Contract;
16.2.7. travel documents purchased by the Insured Person prior to a trip, or documents
confirming their purchase;
16.2.8. travel documents for return to the place of residence;
16.2.9. documents confirming the exchange/return of travel documents for a refund;
16.2.10. a ticket (boarding pass);
16.2.11. a regular passport and/or other document proving the identity of the Insured
Person;
16.2.12. an opinion of a lawyer confirming the referral for primary legal advice on the
event insured; a cash receipt confirming the fact of payment of the legal advice;
16.2.13. a cash receipt confirming the fact of payment of expenses for search and
execution/issuance of duplicates of lost documents;
16.2.14. a cash receipt confirming the fact of payment of expenses for search of
luggage;
16.2.15. documents of law enforcement agencies that confirm the theft or loss of the
passport, the driver’s license of the Insured Person, air and/or railway tickets, luggage;
16.2.16. a certificate of an accident, a CMTPL policy of a vehicle in the event of an
accident;
16.2.17. for foreign citizens or stateless persons – a passport of the country of
citizenship, the document being the basis for staying in the territory of the Russian
Federation (a visa, a residence permit, etc.), the medical expenses insurance contract of the
country of citizenship;
16.2.18. information/documents on the state of his/her health (discharge summary in
case of 24-hour inpatient treatment and an extract from the outpatient card, an information
letter from the Territorial Fund of Compulsory Medical Insurance/Insurance Medical
Organization (organizations, if they have changed over the past three years) which the
Insured Person has chosen for compulsory medical insurance (compulsory health insurance)
on the treatment for the last 3 (three) years, the certificate of a doctor, an expert or a medical
commission;
16.2.19. the Insurer has the right to shorten a list of documents for making the payment
specified in paragraphs 16.2.1-16.2.18.
16.3. At the request of the Insurer, the Insured Person must undergo a medical examination by a doctor appointed by the Insurer. If the Insured Person refuses to undergo the examination, the Insurer has the right to refuse the payment.

<table>
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SECTION 3. INSURANCE FOR “TRIP CANCELLATION” RISK

17. INSURED PROPERTY

17.1. The insured property is the property interests of the Insured Person associated with the risk of unforeseen expenses arising from the cancellation or delay of a flight or the cancellation of a paid trip.

17.2. In these Rules, unless the Contract provides otherwise:

- tourist trip means a trip carried out in accordance with a tourism product provided by a travel agent/tour operator under the Tourism Product Sale Agreement.

Tourism product is a set of transportation and accommodation services provided for the total price (including the cost of excursion services, travel documents, accommodation and (or) other services) under the same Tourism Product Sale Agreement;

- joint tourist trip means a trip taken out jointly with the Insured Person under the same Tourism Product Sale Agreement in which the dates and place of residence (city, hotel, one room in the hotel) coincide as evidenced by documents (tourist voucher, tourist ticket, travel documents (in accordance with clause 6.2.7 of these Rules), confirmation of hotel booking, a statement of payment from a bank account);

- self-organized trip means a trip that provides for the payment of travel documents and/or payment for accommodation in a hotel organized without the involvement of a travel agent or a tour operator and without the conclusion of the Tourism Product Sale Agreement.

18. CASES INSURED AND EXPENSES REIMBURSABLE BY THE INSURER

18.1. The following events that occurred after the entry into force of the Insurance Contract and prevent a trip as confirmed by documents issued by the competent authorities are recognized as events insured, unless otherwise provided by the Insurance Contract:

18.1.1. regarding the cancellation of a trip (in respect of both a tourist and self-organized trips):

18.1.1.1. a death of the Insured Person or his/her close relative or a person making a joint trip with the Insured Person;

18.1.1.2. a sudden acute illness, trauma, poisoning of the Insured Person or his/her close relative or a person making a joint trip with the Insured Person resulting for medical reasons in the need for 24-hour inpatient treatment of more than 2 days not later than the starting date of the trip;

18.1.1.3. an injury to the Insured Person or his/her close relative or a person making a joint trip with the Insured Person accompanied by a bone (bones) fracture that occurred before the starting date of the trip and led to the need for outpatient treatment, but only if there are medical contraindications for the planned trip;

18.1.1.4. a disease that requires the implementation of measures for sanitary protection of the territory of the Russian Federation (hereinafter – especially dangerous infections), according to SR 3.4.2318-08 “Sanitary protection of the territory of the Russian Federation”, “childhood infections” (measles, rubella, chickenpox, scarlet fever, diphtheria, whooping cough, epidemic parotitis) that occurred before the starting date of the trip with the Insured Person or his/her close relative or a person making a joint trip with the Insured Person;
18.1.1.5. a destruction of the dwelling of the Insured Person or a damage thereof making it unfit for living during the term of the Insurance Contract, but not earlier than 15 calendar days prior to the starting date of the trip as a result of:
   - a fire (fire means an emergence of fire capable of independently spreading out of places specially designed for its building and stoking), an explosion, natural disasters, an aircraft crash;
   - a damage caused by water from water, sewage, heating systems;
   - illegal actions of third parties;
18.1.1.6. call of the Insured Person for urgent military service or for military training, provided that the receipt by the Insured Person of a notice is confirmed after the entry into force of the Insurance Contract;
18.1.1.7. a court decision on the necessity of the presence of the Insured Person in connection with the judicial proceedings at the place of residence (registration) and/or the place of a trial during the estimated period of a trip adopted after the entry into force of the Insurance Contract (except when the Insured Person participates in the trial as an expert or fulfills his/her professional duties);
18.1.1.8. a delay of the Insured Person on the way to the airport (railway station, port) for entry into the territory of insurance due to:
   a) an accident involving the Insured Person occurred less than 12 hours before the planned trip and requires the involvement of representatives of the competent authorities;
   b) a damage (breakdown) of a vehicle by which the Insured Person was going to the airport (station, port) to enter the insurance territory the elimination of the consequences of which required the involvement of representatives of authorized state bodies;
18.1.2. regarding the delay of the voyage of a vehicle to be followed by the Insured Person for a period exceeding 6 (six) hours for regular, as well as for charter voyages entered into the global distribution system, due to unfavorable weather conditions, mechanical damage to a vehicle certified for transport (for both a tourist and self-organized trips);
18.1.3. regarding the cancellation of the voyage of a vehicle to be followed by the Insured Person, due to unfavorable weather conditions, mechanical damage to a vehicle certified for transport (for both a tourist and self-organized trips);
18.1.4. regarding the postponement of a tourist trip due to an event insured on the grounds specified in paragraphs 18.1.1-18.1.3 of these Rules (for both a tourist and self-organized trips);
18.1.5. if the Tourism Product Sale Agreement is made only for two persons who are not close relatives (clause 1.5 of these Rules) having a valid Insurance Contract For Insurance of Expenses incurred as a result of the cancellation of a trip, provided that they are living in the same room as confirmed by documents, and in relation to one of the two persons making a joint trip the Insurer recognized the occurrence of the event insured on the grounds specified in paragraphs 18.1.1-18.1.4 of these Rules, the event is recognized as an event insured in respect of the second person making a joint trip with the Insured Person. The Insurance Contract for more than two persons who are not close relatives may not be concluded for this risk. With regard to the insurance of close relatives, as well as the insurance of organized tourist groups, clause 18.1.5 does not apply;
   provided that the events referred to in paragraphs 18.1.1-18.1.4 are not caused and/or not accompanied and/or not associated with:
18.1.1) impossibility to carry out a tourist trip/self-organized trip due to liquidation, bankruptcy, insolvency of the tour operator/travel agent, airline, railway or water carrier, hotel, intermediary, employer providing travel services, or failure to fulfill or improper fulfillment by them of obligations under the Tourism Product Sale Agreement/Agreement on Passenger and Luggage Transportation, etc.; impossibility for the Insured Person through the fault of the carrier to register for the paid route/transportation;

18.1.2) untimely payment by the Policyholder of a trip;

18.1.3) delay or cancellation of a charter flight if these flights are not included in the global distribution system;

18.1.4) withdrawal of the aircraft from flight by any civil aviation service, if this has been notified to the Insured Person in any way prior to a trip;

18.1.5) delay or cancellation of a flight/transportation, cancellation of a paid trip if the Insured Person has been given the opportunity to use an alternative flight without additional charge within 24 (twenty four) hours after the scheduled departure of the delayed flight;

18.1.6) impossibility to carry out a trip as a result of planned treatment of the Insured Person or his/her close relative or a person making a joint trip with the Insured Person;

18.1.7) need to treat diseases (health disorders) that require treatment within the last 6 (six) months;

18.1.8) origin of a state the Insured Person or his/her close relative or a person making a joint trip with the Insured Person preventing a travel/transportation related to:

a) the state of pregnancy (both normal and pathologic);

b) a nervous disease, mental disorder and behavioral disorder; an episodic and paroxysmal disorder of the nervous system (epilepsy and epileptic syndromes, grand mal and petit mal fits, epileptic status, migraines, migraine status, sleep disorders);

c) venereal diseases and sexually transmitted diseases, oncologic (benign, malignant), chronic diseases;

d) a state of incomplete recovery and/or treatment;

e) injuries (wounds) sustained as a result of being in a state of intoxication of any nature and severity and/or as a result of the commission of criminal actions upon the commission of which criminal or administrative proceedings have been instituted;

18.1.9) occurrence of any health disorder associated with the provision of dental care;

18.1.10) failure to obtain the necessary vaccination before traveling to the insurance territory or its complications;

18.1.11) acquisition by the Insured Person/Policyholder of the Tourism Product Sale Agreement or a self-organized trip during the course of treatment or after treatment in a state of incomplete recovery;

18.1.12) any event that occurred while the Insured Person was under the influence of narcotic or other intoxicating substances (including offenses, accidents that occurred when the Insured Person was driving any vehicle);

18.1.13) any event that occurred while the Insured was in a state of alcoholic intoxication (including offenses, accidents that occurred when the Insured Person was driving any vehicle);

18.1.14) any event if the Insured Person has intentionally and knowingly:

- caused damage to his/her health, undertook suicide attempts and other deliberate actions aimed at the occurrence of an event insured, except for cases when the Insured was
brought to such a state by illegal actions of third parties as confirmed by decisions of the relevant bodies;
- deliberately subjected his/her life and health to unjustified/increased risk, except for cases of saving a life for another person, by disregarding safety rules as confirmed by the documents of the relevant authorities;

18.1.15) injury got during driving by the Insured Person of a vehicle without a legal basis for driving, including the absence of a license to drive a vehicle of the appropriate category;

18.1.16) injury of the Insured Person got during flight on any type of aircraft (non-motorized, motor gliders, paragliders, ultralight vehicles, etc.), operating it, except in cases of flight as a passenger on a civil aviation aircraft of a conventional or charter flight operated by a professional pilot;

18.1.17) reimbursement of expenses for transportation to the airport (railway station, port) from which the departure to the planned trip to the insurance territory must be made;

18.1.18) reimbursement of expenses:
a) for moral damage;
b) in case the Insured Person receives indemnity for harm to life, health and/or damage to property of third parties from other persons, including Insurance Companies and those responsible;
c) caused by mistakes made by transport companies, tour operators/travel agents, directly by the Insured Person (his/her close relative or a person making a joint trip with the Insured Person), the Policyholder and other legal entities and individuals related to the preparation, organization and conduct of the trip;

18.1.19) occurrence of circumstances that prevent a trip outside the term of the Insurance Contract;

18.1.20) occurrence of force majeure, such as war, military actions, as well as maneuvers or other military measures and their consequences, strikes, revolutions, insurrections, civil unrest, public disturbance of all kinds and riots; natural disasters and their consequences, epidemics, meteorological conditions, nuclear explosion, direct or indirect effects of radiation, radioactive or other types of infection, any types of emergency situations (catastrophes, etc.), and other force majeure circumstances, as well as cases provided for by the legislation of the Russian Federation;

18.1.21) acts of terrorism and their consequences;

18.1.22) failure to fulfill the obligations imposed by the court (if the Insured Person has not paid taxes, bank loan, rent, alimony, etc.), and transfer of the case for execution to the bailiff service, collectors;

18.1.23) events under paragraphs 18.1.1-18.1.4 are not recognized as insured and expenses on them are not reimbursable, if upon occurrence of an event that has signs of an event insured the Policyholder (the Insured Person) has not in a timely manner, i.e. not later than 2 (two) business days after the occurrence of an event interfering with a trip apply to the tour operator/travel agent for the cancellation of the Tourism Product Sale Agreement or for changing the terms of the trip under the Tourism Product Sale Agreement; for a self-organized trip: to the transport organization – for the cancellation of travel documents; to the hotel – for the cancellation of the hotel reservation.
18.2. The expenses to be reimbursed for “Trip Cancellation” risk, provided that the event is recognized as an event insured, include the expenses of the Policyholder (the Insured Person) incurred in connection with the events specified in clause 18.1 of these Rules, unless otherwise provided in the Contract, in the amount of actual documented expenses:

18.2.1. provided by the Tourism Product Sale Agreement, namely the expenses:

18.2.1.1. specified in the Tourism Product Sale Agreement and paid for by the Insured Person: for payment of accommodation in the hotel room, travel documents, transfer, excursion services;

18.2.1.2. for payment of the cost of tourist services in terms of the amount of expenses for organizing the trip of the Insured Person withheld (not refunded) by a tourist or other organization, taking into account the total cost of tourist services, if they were executed in the form of the same document, and the commission is subject to reimbursement (the difference between the amount paid by the Insured Person (the Beneficiary) and the net value of tourist services specified by the tour operator in the Tourism Product Sale Agreement) in the amount of not more than 500 (five hundred) rubles (including VAT) from the net value of tourist services according to the calculation provided by the tour operator per Tourism Product Sale Agreement;

18.2.1.3. for acquisition of new travel documents in the economy class, including the cost of their re-issue, and in the amount not exceeding the cost of unused travel documents, provided that the original ticket may not be replaced.

The Insurer reimburses the documented expenses associated with the re-issue of travel documents the cost of which is not more than the cost of travel documents in the economy class and not more than their original cost. The Policyholder (the Insured Person) is obliged to take reasonable and available measures in the circumstances to reduce potential losses, including return (surrender) of unused travel documents and refund of their value. In case of non-observance of this condition, the Insurer has the right to deduct the cost of unused travel documents from the amount of reimbursement of the Policyholder’s (the Insured Person’s) expenses.

If it is impossible to use travel documents, they must be surrendered (exchanged for travel documents in accordance with the tourist sheet). At the same time, the Insurer pays for the difference between the new travel documents and the unused ones;

18.2.1.4. for accommodation in the hotel for an unused portion of the period of stay;

18.2.1.5. confirmed by documents in case of rescheduling of a tourist trip due to an event insured on the grounds specified in paragraphs 18.1.1-18.1.4 of these Rules. At the same time, expenses for the surcharge of the cost of the previously paid tourist trip are reimbursed in accordance with the Tourism Product Sale Agreement;

18.2.1.6. related to the delay of the voyage of a vehicle to be followed by the Insured Person for more than 6 (six) hours but no more than 12 (twelve) consequent hours (unless another time interval is provided for in the Insurance Contract), and not more than the sum insured as established by the Insurance Contract regarding the delay of the voyage, provided that the relevant supporting documents issued by the carrier and its representative are provided which confirm such a delay of the voyage. The Insurer pays indemnity for each event insured in the amount of:

- 1,000 (one thousand) rubles for each hour of voyage delay from the 6 (sixth) to the 9 (ninth) hour of delay;
- 2,000 (two thousand) rubles for each hour of voyage delay from the 10 (tenth) to the 12 (twelfth) hour of delay;

18.2.1.7. related to the cancellation of the voyage of a vehicle to be followed by the Insured Person provided that the relevant supporting documents issued by the carrier, its representative confirming such cancellation of the voyage are provided. The Insured Person also must provide a certificate from the tour operator on the non-refundability of tickets. The Insurer pays indemnity for each event insured in the amount of 5,000 (five thousand) rubles, unless otherwise provided by the Insurance Contract;

18.2.1.8. in the event that a voyage delay for more than 6 hours ends with the cancellation of the voyage, the insurance indemnity is paid only once in the maximum amount (either for a voyage delay or cancellation);

18.2.1.9. if the Insurance Contract is not concluded for all tour participants, the Insurer reimburses expenses in direct proportion to the share due to each Insured tour participant from the total cost of the tour under the Tourism Product Sale Agreement;

18.2.2. provided for a self-organized trip, namely the following expenses paid in cash or by bank transfer through the bank card, unless otherwise provided by the Insurance Contract, for acquisition of travel documents issued in the name of the Insured Person, and/or for payment of accommodation in the hotel; for an additional payment for the exchange of equivalent travel documents in case of rescheduling of a trip and/or for an additional payment for accommodation in the hotel with the rescheduling of a trip for not more than for an equal period of time.

18.3. The amount of expenses incurred by the Insured Person is established upon presentation of the original documents prescribed by the legislation of the Russian Federation from the travel agency (from the tour operator) or from another organization, from the transport organization, confirming the costs actually incurred by the Insured Person, the composition of the tourism product under the Tourism Product Sale Agreement, a list of services, statements of bank card accounts or documents confirming cash payment, payment of services on purchase/exchange of travel documents and payment of accommodation in hotels.

18.4. The Insurer’s liability for “Trip Cancellation” risk, unless otherwise expressly stated in the Insurance Contract, covers the expenses incurred not earlier than 5 (five) business days before the date of conclusion of the Insurance Contract, inclusive, in connection with payment of:

a) a tourist trip under the Tourism Product Sale Agreement in a one-time payment;

b) the first installment for a tourist trip under the Tourism Product Sale Agreement – in case of payment by installments (further payments are also included in the insurance indemnity in case of payment by installments provided that the first installment has been paid not earlier than 5 business days before the date of conclusion of the Insurance Contract for the sum insured equal to the full cost of a tourist trip in accordance with the Tourism Product Sale Agreement);

c) travel documents for a self-organized trip;

d) accommodation in a hotel for a self-organized trip;

e) travel documents and payment of accommodation in the hotel, if they are bought at the same date for a self-organized trip.
18.5. If one additional travel participant concludes the Tourism Product Sale Agreement issued by a travel agent or a tour operator, the conclusion of the Travel Insurance Policy on that person is possible only on condition that his/her tourist trip is booked in the same calendar month in which the Tourism Product Sale Agreement was concluded.

18.6. In the Insurance Contract, the parties may provide that exceptions to the insurance specified in clause 18.1 paragraphs 1), 7), 8), 10), 13), 20) - 23) are included in the insurance (the Insurer, for the above circumstances, pays the insurance indemnity), provided that the Insurance Contract (the Policy) specifies in the column “Special Conditions” the paragraphs included in the insurance.

19. SUM INSURED. INSURER’S LIABILITY LIMITS

19.1. The sum insured for “Trip Cancellation” risk is established by agreement of the parties within the costs stipulated by both the Tourism Product Sale Agreement and for a self-organized trip, unless otherwise stipulated by the Contract, per person, and is specified in the Insurance Contract (insurance Policy) for each Insured Person.

19.2. The sum insured equals to:

19.2.1. for a tourist trip – the cost of services provided by a tour operator/travel agent in accordance with the Tourism Product Sale Agreement;

19.2.2. for a self-organized trip – the cost of a particular service for payment of a hotel and/or payment for travel documents.

19.3. The Insurer has the right to set liability limits and unconditional franchise for certain categories (items of expenditure) provided for in Chapter 18 of these Rules.

20. OBLIGATIONS OF THE PARTIES UPON OCCURRENCE OF THE EVENT INSURED

20.1. Upon occurrence of an event that has signs of an event insured, the Policyholder (the Insured Person) or a person making a joint tourist trip with the Policyholder (the Insured Person) is obliged:

a) promptly, as soon as he/she becomes aware, to notify the Insurer of the event occurred;

b) in a timely manner, i.e. within 30 (thirty) business days after the occurrence of an event that has signs of an event insured that occurred before the commencement of a trip, or 30 (thirty) business days after the return from the trip, to declare its occurrence in writing to the Insurer indicating in the declaration the nature and circumstances of the event that has signs of an event insured;

c) to apply in a timely manner, i.e. within 2 (two) business days after the occurrence of an event that has signs of an event insured to a tour operator/travel agent for the cancellation of the Tourism Product Sale Agreement or for rescheduling of a trip under the Tourism Product Sale Agreement; for a self-organized trip: to the transport organization – for the cancellation of travel documents; to the hotel – for the cancellation of the hotel reservation.

The declaration must specify the nature and circumstances of the event that has signs of an event insured. The declaration must be accompanied by originals or copies certified by a notary or in accordance with the procedure established by law, of the following documents:

20.1.1. on the expenses specified in clause 18.2:
20.1.1.1. transportation documents (travel documents acquired by the Insured Person prior to the commencement of a trip or documents confirming their purchase, travel documents for return to the place of residence, documents confirming the exchange/surrender of travel documents; boarding passes, etc.) of transport companies and other organizations, whose services were used/not used by the Insured Person in connection with the cancellation of the trip, confirming the existence of losses associated with the cancellation of travel documents, the refusal of the booked and paid hotel room, etc.;

20.1.1.2. documents of transport companies in case of delay or cancellation of a voyage confirming the fact and time of delay or cancellation of the voyage;

20.1.1.3. documents and information confirming the occurrence of the event stipulated in the Insurance Contract by the Insured Person or his/her close relatives or a person making a joint tourist trip with the Insured Person required to determine the nature of the event insured, namely:

20.1.1.3.1. if it is impossible to travel due to:

a) death, acute sudden illness, trauma, poisoning resulting for medical reasons in the need for 24-hour inpatient treatment lasting more than 2 days not later than the starting date of a trip – a discharge summary from a medical institution (inpatient facility): a death certificate; documents confirming the kinship of the Insured Person and a close relative; official documents from the competent authorities (certificates of law enforcement and judicial bodies) confirming the fact of an accident (accident report) and the circumstances of the incident if the event was caused by an accident and the Insured Person was a driver: the results of a test or examination for a state of intoxication, a driver’s license; an extract from the patient history for the last 6 months, a certificate of incapacity of work);

b) injury of the Insured Person or close relative accompanied by a fracture of a bone (bones) that occurred prior to the commencement of a trip and led to the need for outpatient treatment – an extract from the outpatient card from a medical facility for the entire period of treatment, documents confirming the kinship of the Insured Person and a close relative; official documents from the competent authorities (certificates of law enforcement and judicial bodies) confirming the fact of an accident (accident report) and the circumstances of the incident, the results of a test or examination for a state of intoxication;

c) especially dangerous infections, “childhood infections” that occurred before the trip:

for especially dangerous infections: for outpatient treatment – an extract from the outpatient card from a medical institution for the entire treatment period; for 24-hour inpatient treatment – a discharge summary for 24-hour inpatient treatment from a medical institution for the entire treatment period; documents confirming the kinship of the Insured Person and a close relative in the case of outpatient treatment of a close relative (marriage certificate, birth certificate, child adoption certificate, guardian certificate (decision of a guardianship authority to appoint the person as a guardian or trustee));

for childhood infections: a certificate on being under quarantine in occasion of the past infectious disease; for outpatient treatment – an extract from the outpatient card from a medical institution for the entire period of quarantine measures; for 24-hour inpatient treatment – a discharge summary for 24-hour inpatient treatment from a medical institution for the entire treatment period; documents confirming the kinship of the Insured Person and a close relative in the case of outpatient treatment of a close relative (marriage certificate, birth
certificate, child adoption certificate, guardian certificate (decision of a guardianship authority to appoint the person as a guardian or trustee));

20.1.1.3.2. in case of destruction or damage to a dwelling – documents confirming the right to own, use, dispose of the dwelling, an original opinion of the commission on recognizing the premises as unfit for permanent residence, documents of the competent authorities confirming the fact of the event occurred – originals or certified copies of documents from the competent authorities (Ministry of Emergency Situations, Department of Internal Affairs, operating organization (Local Building Administration, etc.), police, etc.);

20.1.1.3.3. call to the invitation in military enlistment office for calling to military service or military training – a notice with confirmation of the date of receipt;

20.1.1.3.4. judicial proceedings – summons with confirmation of the date of receipt;

20.1.1.3.5. delay of the Insured Person on the way to the airport (railway station, port) due to an accident and/or damage (breakdown) of a vehicle: the records of the internal affairs bodies and/or the relevant administrative services confirming the fact of damage, documents from the competent authorities confirming the reason and duration of delay, certificate of an accident, and:

20.1.2. on the expenses provided by the Tourism Product Sale Agreement specified in paragraph 18.2.1 of these Rules, unless otherwise provided by the Insurance Contract:

20.1.2.1. the Tourism Product Sale Agreement and the Insurance Contract;

20.1.2.2. documents confirming the receipt by a tour operator/travel agent of funds for payment of the Tourism Product Sale Agreement;

20.1.2.3. documents confirming the return of a part of funds by a tour operator/travel agent in accordance with the provisions of cancellation of a trip by a tour operator/travel agent in case of cancellation of the trip (return calculation and cash order), including the date of filing the application from the Policyholder (the Insured Person) for cancellation of the trip under the Tourism Product Sale Agreement and the date of cancellation of the trip under the Tourism Product Sale Agreement by a tour operator/travel agent;

20.1.2.4. in case of implementation of the Tourism Product Sale Agreement through a travel agent, to provide a copy of the Agreement between a tour operator and a travel agent;

20.1.2.5. financial documents of a tour operator/travel agent confirming the actual expenses incurred by a tour operator/travel agent in connection with the implementation of the Tourism Product Sale Agreement, the costs of the Policyholder (the Insured Person) incurred as a result of the refusal of a trip in accordance with the Tourism Product Sale Agreement;

20.1.2.6. a certificate of a tour operator/travel agent with a detailed indication of the services paid under the Tourism Product Sale Agreement, including paid fines for the cancellation of a tour and other non-refundable expenses.

20.1.3. on expenses provided for a self-organized trip specified in paragraph 18.2.2 of these Rules, unless otherwise provided by the Insurance Contract:

20.1.3.1. documents confirming cash payment/payment by bank card: cash receipt, bank statement certified by a bank;

20.1.3.2. documents from the transport organization confirming the expenses of the Policyholder (the Insured Person) due to cancellation/exchange of the travel documents;
documents from a hotel confirming the expenses of the Policyholder (the Insured Person) due to cancellation of the hotel reservation.

20.2. The Policyholder (the Insured Person) is obliged to immediately notify a tour operator/travel agent about the cancellation of a trip or about rescheduling of a trip within 2 (two) business days upon occurrence of an event preventing a trip in order to minimize the penalties imposed for the cancellation of a trip in the Tourism Product Sale Agreement. In case the Insured Person has not applied within 2 (two) business days for the cancellation of a trip or its rescheduling, the Insurer has the right to calculate the insurance indemnity based on the penalties provided under the Tourism Product Sale Agreement upon application of the Insured Person not later than the second day after the declared event, unless it is proved that the Insured Person/his/her representative had grounds preventing timely application for the cancellation of a trip or its rescheduling.

20.3. The Policyholder (the Insured Person) is obliged to give written explanations to the Insurer’s requests related to the occurrence of an event insured.

20.4. The Policyholder (the Insured Person) is obliged to take measures to cancel travel documents and to minimize the amount of losses specified in clause 18.1 of these Rules, for which purpose immediately, within 2 (two) business days after the event preventing a trip, to declare to the relevant organization about the cancellation of a trip and travel documents. If the Insured Person has not applied within 2 (two) business days for the cancellation of a trip and travel documents, the Insurer is entitled to calculate the insurance indemnity based on the penalties provided for under the Tourism Product Sale Agreement upon application of the Insured Person not later than the second day after the declared event, unless it is proved that the Insured Person/his/her representative had grounds preventing timely application for the cancellation of a trip and travel documents.

21. PROCEDURE FOR MAKING INSURANCE PAYMENTS

21.1. The insurance payment is made to the Insured Person (the Policyholder) who incurred expenses due to cancellation of a trip as specified in the Insurance Contract (insurance Policy).

21.2. For insurance payment on a tourist trip organized by a travel agent or a tour operator, upon occurrence of an event insured, the Insured Person (the Policyholder) is obliged to submit to the Insurer an application for payment in accordance with the form established by the Insurer accompanied by the documents specified in clause 20.1.2 of these Rules, as well as originals or copies certified by a notary or in accordance with the procedure established by law (payment documents – only originals) of the following documents:

21.2.1. the Insurance Contract;

21.2.2. a regular passport and/or other document proving the identity of the Policyholder (the Insured Person);

21.2.3. the Tourism Product Sale Agreement, a cash voucher or a strict accounting form “tourist sheet” for the payment of those services;

21.2.4. an official letter on the letterhead of a tour operator:
   - with the indication of the cost of a tour and all participants of the tour under the Tourism Product Sale Agreement; the cost of a tour for each participant of a tour;
   - with the calculation of the refund amount of the cost of a trip under the Tourism Product Sale Agreement certified by the director and chief accountant of the organization;
21. For insurance payment on a self-organized trip upon occurrence of an event insured, the Insured Person (the Policyholder) is obliged to submit to the Insurer an application for payment in accordance with the form established by the Insurer accompanied by the documents specified in clause 20.1.3 of these Rules, as well as originals or copies certified by a notary or in accordance with the procedure established by law (payment documents – only originals) of the following documents:

21.3.1. the Insurance Contract;
21.3.2. a regular passport and/or other document proving the identity of the Policyholder (the Insured Person);
21.3.3. an extract from the bank card account certified by the bank’s stamp, indicating the date of writing off of the funds, the amount and the recipient, or documents confirming cash payment reflecting the payment of tickets, hotel accommodation, penalty for cancellation of the reservation, refund for the surrender of unused travel documents;
21.3.4. a printout of booking confirmation with an identification number or code, with indication of a recipient of the service, the cost of booking and a reference to the terms of the reservation;
21.3.5. documents confirming the occurrence of an event insured:
21.3.5.1. a discharge summary;
21.3.5.2. a document from the carrier confirming the delay or cancellation of a voyage with the carrier’s note, including the voyage number and the place where the delay occurred, as well as a document confirming that the voyage was not chartered and was included in the global distribution system.

21.4. The insurance payment is made:
21.4.1. for the expenses specified in clause 18.2.1 of these Rules in the amount of a difference between the actual expenses incurred by the Policyholder (the Insured Person) taken into account in determining the sum insured and the amount of expenses refunded by a tour operator/travel agent and/or transport company in case of timely application by the Insured Person (within 2 (two) business days upon occurrence of an event preventing a trip), minus the franchise, but not more than the sum insured and liability limits established in the Contract (insurance Policy) for this type of risk and/or expenses;
21.4.2. for the expenses specified in clause 18.2.2 of these Rules in the amount of the sum withheld by the respective organization upon cancellation of the reservation in the case - with the calculation of actual expenses incurred by the tour operator/travel agent related to the performance of obligations under the Tourism Product Sale Agreement, certified by the director and chief accountant of the organization, indicating the withholding cost of each service included in the tourist product for each participant in the tour;
- containing compulsorily the date of the Policyholder’s application to a travel agent/tour operator for the cancellation of a trip under the Tourism Product Sale Agreement;
21.2.5. a ticket (boarding pass);
21.2.6. in case of the sale of a tourism product through a travel agency – an agreement between a tour operator and a travel agency;
21.2.7. claims and other documents necessary to assert a claim to the carrier and/or the organization responsible for the delay or cancellation of a voyage;
21.2.8. a document confirming the delay or cancellation of a voyage with the carrier’s note, including the voyage number and the place where the delay occurred.
of the application by the Insured Person not later than the second day after the declared event, and not refundable according to the conditions of booking published by the carrier or hotel. A part of the sum refundable by the carrier or hotel upon cancellation of the reservation according to published conditions of booking does not constitute an insurance payment and is not refundable.

21.5. If the Insured Person has received an indemnity from third parties (including a carrier, another Insurance Company, a tour operator, etc.), the Insurer pays the difference between the amount payable under the Insurance Contract and the amount received from third parties, but not more than the real value of a tourism product or a self-organized trip. The Insured Person is obliged to inform the Insurer of the receipt of such sums.

<table>
<thead>
<tr>
<th>Code of an insurance program for “Trip Cancellation” risk</th>
<th>A list of events insured according to the following clauses of these Rules</th>
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<tr>
<td>OR1</td>
<td>18.1.1.1.-18.1.1.8.</td>
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<tr>
<td>OR2</td>
<td>18.1.1.1.-18.1.1.8., 18.1.2., 18.1.3., 18.1.4.</td>
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</tbody>
</table>
SECTION 4. INSURANCE FOR “ACCIDENT” RISK

22. INSURED PROPERTY
22.1. The insured property is the property interests of the Insured Person connected with causing harm to health, as well as with the death of the Insured Person as a result of an accident or a dangerous disease. The recognition by the Insurer of the event occurred as insured and payment of insurance indemnity for any other risk provided for in these Rules (including “Medical and Emergency Assistance” risk) is not (automatic) recognition of its insurance for “Accident” risk.

23. EVENTS INSURED AND EXPENSES REIMBURSABLE BY THE INSURER
23.1. In these Rules:
23.1.1. an accident is understood as a sudden, unforeseen, unintended, short-term external event or impact, the nature, time and place of which may be uniquely identified and which entailed bodily injury or other impairment of the body’s functions or death of the Insured Person, not as a consequence of the disease, occurred during the insurance period specified in the Contract and in the insurance territory, regardless of the will of the Insured Person and/or the Policyholder and/or the Beneficiary. The acute or chronic diseases and their complications (both previously diagnosed and newly diagnosed) provoked by external factors, in particular myocardial infarction, stroke, aneurysm, tumors, functional organ failure, congenital anomalies of organs, are not considered as accident unless otherwise stipulated in the Contract;
23.1.2. A dangerous disease is defined as a disturbance of the state of health of the Insured Person, not caused by an accident, the diagnosis of which was made for the first time during the term of the Insurance Contract by a qualified medical professional on the basis of objective medical symptoms known to the medical profession, as well as the results of special analysis (Annex No. 5 to these Rules).
23.2. The events insured for the Accident risk, unless otherwise provided by the Insurance Contract, are the following:
23.2.1. trauma resulting from an accident, accidental acute poisoning by chemical substances and poisons of biological origin (including the toxin that causes botulism). These events are recognized as events insured if they occurred under the Insurance Contract in respect of the Accident risk in the insurance territory and were accompanied by damage to the health of the Insured Person provided by the option “Tables of Insurance Payments” (Annex 6 to these Rules);
In these Rules, a trauma is understood as a disturbance of the structure of living tissues and the anatomical integrity of organs, which is the result of a momentary or short-term external action of physical (with the exception of electromagnetic and ionizing radiation) or chemical factors of the environment, diagnosed on the basis of objective medical symptoms known to the medical profession.
In these Rules, accidental acute poisonings include sharply developing painful changes and protective reactions of the body of the Insured Person caused by a momentary or short-term impact of a chemical substance accidentally received from the environment into the body and possessing toxic (poisoning) properties. Infectious diseases, including those accompanied by intoxication (salmonellosis, dysentery, etc.) do not belong to incidental acute
poisoning;

23.2.2. disability I, II, III group or category “disabled child”, initially established by the Insured Person due to the following events that occurred during the period of the Insurer’s liability under the Insurance Contract for the “Accident” risk in the insurance territory and caused the disability: injuries which were the result of an accident or incorrect medical manipulation, accidental acute poisoning by chemical substances and poisons of biological origin (including the toxin that causes botulism). In this case, disability to the Insured Person should be established in a period not exceeding 12 months from the date of occurrence of the event specified in this paragraph and which caused the disability;

23.2.3. death of the Insured Person due to the following events that occurred with him/her during the period of the Insurer’s liability under the Insurance Contract for the “Accident” risk in the insurance territory and caused death: injury resulting from an accident or improper medical manipulation, accidental acute poisoning by chemicals and poisons of biological origin, as well as from strangulation due to accidental ingress of foreign bodies into the respiratory tract, drowning, anaphylaxis shock, hypothermia, provided that the death of the Insured Person occurred in a period not exceeding 6 (six) months from the date of occurrence of the event specified in this paragraph, and cause of death;

23.2.4. primary diagnosis of a dangerous disease in the Insured Person for the first time diagnosed and first developed during the validity period of the Insurance Contract and/or the consequences of the disease stipulated in the “List of Dangerous Diseases” (Annex No. 5 to these Rules), the diagnosis of which has been confirmed by an expert doctor appointed by the Insurer. A time franchise may be established for a dangerous disease. The list of dangerous diseases for which insurance is provided is agreed by the Insured Person with the Insurer from among the prescribed dangerous diseases in Annex No. 5 to these Rules and is specified in the Insurance Contract;

23.2.5. disability I, II, III group or category “disabled child”, initially established by the Insured as a result of the onset of the consequences of a dangerous disease. In this case, disability to the Insured Person should be established in a period not exceeding 12 months from the date of occurrence of the event specified in this paragraph and which caused the disability;

23.2.6. death of the Insured Person due to a dangerous disease, provided that the death of the Insured Person occurred within a period not exceeding twelve (12) months from the date of confirmation of the diagnosis after the expiry of the temporary deductible established in accordance with Annex No. 5 to these Rules;

23.2.7. temporary incapacity for work of the Insured Person (complete loss of the Insured Person’s ability to work for a certain limited period of time) as a result of the consequences of an accident that occurred to the Insured Person during the insurance period (hereinafter – the risk/event insured “Temporary disability as a result of an accident”), citizens, provided that the events referred to in paragraphs 23.2.1-23.2.7 are not accompanied and/or not connected with:

23.2.1) committing an intentional crime by the Insured Person;
23.2.2) an accident occurred with the Insured in places of deprivation of liberty;
23.2.3) poisoning with alcohol-containing and/or narcotic, toxic substances of the Insured Person if the competent authorities do not establish the fact of their forced administration or forced use;
23.2.4) any event that occurred while the Insured Person was under the influence of narcotic or other intoxicating substances (including offenses, accidents that occurred during the driving by the Insured Person any vehicle);

23.2.5) any event that occurred while the Insured Person was in alcoholic intoxication (including offenses, accidents that occurred during the driving by the Insured Person any vehicle);

23.2.6) injuries sustained during the driving vehicle by the Insured Person without a legal basis for its driving, including the lack of rights to drive a vehicle of the appropriate category;

23.2.7) an injury of the Insured Person got during flight on any type of aircraft (non-motorized, motor gliders, paragliders, ultralight vehicles, etc.), operating it, except in cases of flight as a passenger on a civil aviation aircraft of a conventional or charter flight operated by a professional pilot;

23.2.8) an injury got during the Insured Person’s going in for any kind of sport and participation in training and sporting events, participation in competitions of athletes on a professional or amateur level, and also any active rest, except for the Insurance Contracts with the condition “Sports” reflected in the column “Special Conditions” of the Policy according to clause 3.4.1 of these Rules;

23.2.9) an injury got during climbing, mountaineering, ice climbing, heli-skiing, paragliding; an injury got during diving for depth of more than 40 meters and/or using gas mixtures in which the oxygen content differs from 21 (twenty-one) per cent and/or without the certificate of the scuba diver association, regardless of whether the Contract (Policy) includes the condition “Sports” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.1 of these Rules;

23.2.10) an injury got by the Insured Person when using motor vehicles (motorcycles, jet skis, motor scooters, mopeds, motorbikes, scooters, quads, all-terrain vehicles, snowmobiles, segways, go-carting, rafting), regardless of whether the Policyholder (the Insured Person) was a driver or passenger, with the exception of the Insurance Contracts with the condition “Sports” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.1 of these Rules;

23.2.11) an injury or a state sustained during the Insured Person’s engagement in any type of work activity, including but not limited to, during any work that increases the probability of injury, both in professional and non-professional activities, with the exception of the Insurance Contracts with condition “Profession” reflected in the column “Special Conditions” of the Policy in accordance with clause 3.4.3 of these Rules;

23.2.12) an injury of the Insured prior to the beginning of the Insurer’s liability under the Insurance Contract, as well as its consequences;

23.2.13) a trauma caused by convulsive seizures with epilepsy;

23.2.14) fulfillment by the Insured of any type of professional work not provided for under the terms of his/her Employment Agreement (contract);

23.2.15) occurrence of an event insured through the fault of the employer of the Insured Person;

23.2.16) service of the Insured Person in the armed forces of any state and any formations;
23.2.17) the occurrence of force majeure, such as war, military actions, as well as maneuvers or other military measures and their consequences, strikes, revolutions, insurrections, civil unrest, public disturbance of all kinds and riots; natural disasters and their consequences, epidemics, meteorological conditions, nuclear explosion, direct or indirect effects of radiation, radioactive or other types of infection, any types of emergency situations (catastrophes, etc.), and other force majeure circumstances, as well as cases provided for by the legislation of the Russian Federation;

23.2.18) terrorist acts and their consequences;

23.2.19) the state of pregnancy and its complications, as well as all related medical, obstetrical and other procedures;

23.2.20) temporary disablement for pregnancy, child care or nursing, temporary disability due to dental treatment (with the exception of damage resulting from an accident), sexually transmitted diseases, any diseases of the nervous system, mental disorders, regardless of their classification, diseases, acquired in the treatment of popular (alternative) medicine;

23.2.21) recognition of the Insured Person as missing/declaration of the Insured Person as deceased by a court order;

23.2.22) compensation of expenses:
   a) for non-pecuniary damage;
   b) in the event that the Insured Person receives compensation for harm from other persons, including the Insurance Companies and those responsible;

23.2.23) any event if the Insured Person has intentionally and knowingly:
   - caused damage to his/her health, undertook suicide attempts and other deliberate actions aimed at the occurrence of an event insured, except for cases when the Policyholder was brought to such a state by illegal actions of third parties as confirmed by decisions of the relevant bodies;
   - deliberately subjected his/her life and health to unjustified/increased risk, except for cases of saving a life for another person, by disregarding safety rules as confirmed by the documents of the relevant authorities.

23.3. Insurance for “Accident” risk in terms of the risk insured “Disability I, II, III group or category”, “disabled child”, unless otherwise provided by the Insurance Contract, is not applied against citizens of foreign states or stateless persons temporarily staying in the Russian Federation, as well as those who do not have a residence permit, temporary residence permits, permanent/temporary registration in the territory of the Russian Federation, refugee status.

23.4. By the agreement of the Policyholder and the Insurer, the Insurance Contract may stipulate the Insurer’s liability for the events listed in clause 23.2 paragraphs 5), 8), 9), 10), 11), 17), 18), 23) of these Rules, as well as in the event that the Insurer makes a decision on insurance of persons engaged in activities related to the increased danger, including the envisaged items 3.4.1, 3.4.3, 23.2 paragraph 15), the insurance premium is paid by them in accordance with the raising coefficients established by the Insurer. At the same time, the relevant events should be specified explicitly in the Insurance Contract.

24. PROCEDURE FOR DETERMINING THE AMOUNT OF INSURANCE PAYMENTS
24.1. In the events provided for in paragraph 23.2.1 of these Rules, the amount of insurance payment is determined in a certain percentage of the sum insured in accordance with the variant of the “Table of Insurance Payments” (Annex No. 6 to these Rules), indicated in the column “Special Terms” of the Policy, unless otherwise provided by the Insurance Contract.

24.2. When the group (category) of the disability is identified to the Insured Person (clause 23.2.2 of these Rules), the amount of the insurance payment shall be determined in the following amounts from the insured sum, unless otherwise provided by the Insurance Contract:

24.2.1. A person who was not an invalid before entering into the Insurance Contract:
- 100% establishing the I group of disability;
- 80% establishing the II group of disability;
- 60% establishing the III group of disability;
- 100% establishing the category of “disabled child”;

24.2.2. A person who was concerned to III group of disability before the conclusion of the Insurance Contract:
- 100 % establishing the I group of disability;
- 80 % establishing the II group of disability.

At the same time, in connection with the establishment of the group (category) of the disability, the Insured Person shall be paid a deduction of the amount of the earlier payment if it was made in connection with the infliction of harm to the health of the Insured (clause 23.2.1 of these Rules), which caused (one of the reasons) determination of disability.

24.3. In connection with the death of the Insured Person (clause 23.2.3 of these Rules), the amount of the insurance payment is 100% of the insurance amount less payments in connection with insured events stipulated in clauses 23.2.1, 23.2.2, if they were or should be made according to previously submitted documents.

24.4. When an event provided for in paragraph 23.2.4. of these Rules occurs, the amount of insurance payment is determined by the limit of the sum insured established separately for clause 23.2.4. The insurance contract is indicated in the Policy field “Special Terms”.

24.5. In case of occurrence of an event stipulated by paragraph 23.2.5, the amount of insurance payment is determined in the following amounts from the insured sum established under clause 23.2.5., unless otherwise provided by the Insurance Contract:

24.5.1. A person who was not an invalid before the conclusion of the Insurance Contract:
- 100% establishing the I group of disability;
- 80% establishing the II group of disability;
- 60% establishing the III group of disability;
- 100% establishing the category of «disabled child»;

24.5.2. A person who was concerned to III group of disability before the conclusion of the Insurance Contract:
- 100% establishing the I group of disability;
- 80% establishing the II group of disability.

24.6. In connection with the death of the Insured (clause 23.2.6 of these Rules), the amount of the insurance payment is 100% of the sum insured.
24.7. When an event occurs as provided for in paragraph 23.2.7. of these Rules, the amount of insurance payment is determined in the amount of 0.2% of the insured sum for each day of incapacity for work of the Insured Person (according to the incapacity sheet)/inpatient treatment, starting from the 1st day of temporary incapacity for work/inpatient treatment, but not more than 20% of the insurance the amount for the entire insurance period, unless otherwise provided by the Contract.

24.8. The total amount of insurance payments for “Accident” risk may not exceed the amount of the insured sum established for the Insured Person for this risk.

24.9. If, as a result of the consequences of one accident, payment is made in accordance with clauses 24.1., 24.2., 24.3., 24.7. the Insurer makes the payment in the largest amount. If earlier payments were made, the Insurer makes a payment less the payments made earlier. For all insurance programs, articles and points of the tables, payments for the consequences of one accident are not summarized. Each subsequent payment is carried out if the amount of insurance coverage under the Insurance Rules exceeds the previous payment, with payment being made only in the amount of the difference between the large amount of insurance coverage and the payment already made for this accident.

24.10. If the Insurance Contract concurrently provides for payments under clause 24.4, clause 24.5. and paragraph 24.6, the Insurer shall pay the payment under clause 24.4. in the amount of the limit of the sum insured, set separately for paragraph 23.2.4. Under clauses 24.5 and clause 24.6, each subsequent payment is made if the amount of insurance coverage under the Insurance Rules exceeds the previous payment, with payment being made only in the amount of the difference between the large amount of insurance coverage and already implemented payments under clause 24.5 and paragraph 24.6.

25. SUM INSURED. INSURER’S LIABILITY LIMITS

25.1. The coverage is established as a single sum for the insurance of “Accident” risk for the Insured Person.

25.2. In the Insurance Contract, an unconditional franchise for each insured event may be established – a part of the damage caused by the occurrence of the insured event, which is not reimbursable by the Insurer. When establishing an unconditional franchise, the Insurer makes an insurance payment less the franchise.

25.3. In the Insurance Contract, by agreement of the parties, liability limits for insurance payments and/or unconditional/time franchises for each event insured for the cases specified in paragraph 23.2 of these Rules may be established with respect to paragraph 23.2.4. A time franchise may be established in accordance with Annex No. 5 to these Rules.

26. RIGHTS AND OBLIGATIONS OF THE PARTIES

26.1. The Policyholder has the right to make proposals for changing the terms and conditions of the Insurance Contract, including those relating to the Insured Person and the amounts of insurance amounts established by it, in accordance with the rules and legislation of the Russian Federation.

26.2. The Policyholder is obliged:

26.2.1. upon occurrence of an event (events) with the Policyholder (the Insured Person) from the stipulated in paragraph 23.2. of these Rules, immediately, from the moment when it
became aware of the occurrence of such an event, to notify the Insurer in any way available to him, allowing objectively to fix the fact of the appeal.

The obligation of the Policyholder to inform about the occurrence of a specific event with the Policyholder (the Insured Person) may be performed by the Beneficiary;

26.2.2. during the term of the Insurance Contract, to immediately inform the Insurer of any changes in the circumstances that were reported during the conclusion of the Insurance Contract and affected the determination of the degree of insurance risk if these changes could increase the insured risk;

26.2.3. to comply with the provisions of the Insurance Contract and other documents securing the Contractual Legal Relationship between the Policyholder and the Insurer related to the conclusion, execution or termination of these legal relationships.

26.3. The Insurer is obliged:

26.3.1. to acquaint the Policyholder with the terms of insurance;

26.3.2. to give explanations on all matters relating to the terms of the Insurance Contract;

26.3.3. to give an Insurance Policy to the Policyholder;

26.3.4. to provide the confidentiality and security of the personal data of the Policyholder (the Insured Person, the Beneficiary) received from the Policyholder during their processing;

26.3.5. in the occurrence of an event insured with the Insured Person after receiving all necessary documents, to take a decision on the insurance payment or on the refusal of the insurance payment in accordance with clause 9.8. of these Rules.

26.4. The Policyholder (the Insured Person) has the right:

26.4.1. upon occurrence of the event having signs of an insured event, to demand performance by the Insurer of the accepted obligations under the Insurance Contract concluded in its favor;

26.4.2. upon the death of the Insured being an individual, the liquidation of the Policyholder being a legal entity in the manner provided for by the legislation of the Russian Federation, and also by agreement between the Policyholder and the Insurer, to assume the obligations stipulated in paragraph 8.6. and 8.8 of these Rules.

26.5. The Insurance Contract may provide for other rights and obligations of the Parties that do not contradict the legislation of the Russian Federation.

26.6. The rights and obligations of the Policyholder (the Insured Person, the Beneficiary) under the Insurance Contract may not be transferred to anyone without a written consent of the Insurer.

27. A LIST OF DOCUMENTS FOR INSURANCE PAYMENT

27.1. Upon occurrence of the event having signs of an event insured, the Insurer receives from the Policyholder (Insured Person), and in the event of the death of the Policyholder (the Insured Person) from the Beneficiary, and if he/she is not appointed, the heir (heirs) of the Policyholder (the Insured Person), originals or copies certified by a notary or in accordance with the procedure established by law (payment documents – only originals) of the following documents:
a) a written application for payment in accordance with the established form, indicating the credible circumstances under which the event occurred in it, as well as full bank details and the account number for transfer of the insurance payment;

b) document proving the identity of the applicant;

c) insurance Policy (Insurance Contract);

d) medical documents confirming the fact that the Insured Person sustained injuries and/or accidental acute poisoning during the validity period of the insurance contract, the circumstances of their receipt, a full diagnosis, the terms of treatment, medical and diagnostic measures; medical documents confirming the fact of the primary diagnosis of a dangerous disease, including serological and immunological studies, a certificate of the center for hygiene and epidemiology of Federal Service on Surveillance for Consumer Rights Protection and Human Well-Being on the registration of an infectious disease;

e) primary radiographs, if the injury was accompanied by bone lesions (dislocations, subluxations, epiphysiolysis, fractures, detachment of bone fragments);

f) documents of the competent authorities on the investigation of the circumstances of receipt by the Insured Person of trauma, accidental acute poisoning. These documents should contain information about the facts of the occurrence of the insured event with the Insured Person and the nature of the damages received by him;

j) a report on the accident at work or a similar document drawn up in the insurance territory is submitted if necessary, when the connection of the claimed case with the performance by the Insured Person under the Contract of Insurance of Official Responsibilities;

h) a certificate of the medical and social expertise body (MSE) on the establishment of an invalidity group for the Insured to be presented in case of disability;

i) application for the medical and social expertise or the Protocol for the conduct of medical and social expertise, or a reverse coupon;

j) certificate of death of the Insured to be attached in case of death;

k) medical document indicating the cause of death of the Insured Person (certificate of death of the Insured Person, etc.) to be submitted in the event of death;

l) documents on autopsy of the body of the Insured Person if an autopsy was performed;

m) certificate of the right to inheritance to be represented only by the heir or heirs of the Policyholder (the Insured Person);

n) information/documents on the state of his/her health (discharge summary in case of 24-hour inpatient treatment and an extract from the outpatient card, an information letter from the Territorial Fund of Compulsory Medical Insurance/Insurance Medical Organization (organizations, if they have changed over the past three years) which the Insured Person has chosen for compulsory medical insurance (compulsory health insurance) on the treatment for the last 3 (three) years, the certificate of a doctor, an expert or a medical commission);

o) disability certificate or other document confirming the fact and duration of temporary incapacity for work of the Insured Person;

p) certificate of the right to inheritance;

q) test result or examination for alcohol in the event of an injury or an road traffic accident;

r) driver’s license.
27.2. All submitted documents from medical institutions or competent organizations must be presented on the appropriate form and certified with a signature and appropriate seal, if the document is not compiled on a blank, the stamp of the institution that issued the document is mandatory.

27.3. The day of the insurance payment is the date of writing off the funds from the account of the Insurer in the bank. The transfer of amounts due is made at the expense of the beneficiary’s funds.

27.4. Insurance payment can be made to:
27.4.1. the Insured Person;
27.4.2. the Beneficiary, in case of death of the Insured Person;
27.4.3. to the heirs of the Insured Person if:
   - the Insured Person died without receiving the insurance payment due to him/her in accordance with clauses 23.2.1., 23.2.2, 23.2.4., 23.2.5;
   - the Beneficiary intentionally deprived the Insured Person of life or deliberately caused him bodily injuries, which entailed his death;
   - the Beneficiary was not appointed or died earlier than the Insured Person;
   - in one day the death of the Insured and the Beneficiary occurred before the decision was taken on the insurance payment;
27.4.4. heirs of the Beneficiary, if after the death of the Insured Person, the death of the Beneficiary was followed, and he did not have time to receive the insurance payment due to him;
27.4.5. as stipulated by the legislation of the Russian Federation.

27.5. The insurance payment is made to the person entitled to receive it under the Insurance Contract, regardless of the amounts due to him/her under other Insurance Contracts, as well as on compulsory social insurance, social security and compensation for harm.

<table>
<thead>
<tr>
<th>Codes of insurance programs for “Accident” risk</th>
<th>A list of events insured according to the following paragraphs of these Rules</th>
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</thead>
<tbody>
<tr>
<td>NR1</td>
<td>23.2.1.</td>
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<tr>
<td>NR2</td>
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<td>NR6</td>
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<td>NR7</td>
<td>23.2.4.- 23.2.6.</td>
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SECTION 5. INSURANCE FOR “LUGGAGE” RISK

28. INSURED PROPERTY
28.1. The insured property is the property interests of the Policyholder (the Insured Person), not inconsistent with the legislation of the Russian Federation, connected with the risk of loss and/or delay of luggage officially handed over to the carrier, while the Insured Person’s following to and from the insurance territory.

28.2. For the purposes of insurance under these Rules for the Luggage risk, unless otherwise provided by the Contract:
- luggage is understood as one indivisible place of storage – a luggage piece – a suitcase/travel bag/rucksack and its contents: personal items of the Insured Person, imported to the territory of insurance and exported from the insurance territory, belonging to the Insured Person on the right of ownership, not leased, not borrowed, registered in the name of the Insured Person, which is intended to be used solely for personal purposes, officially handed over to the carrier with the obligatory registration of the luggage tag for each luggage piece.

29. EVENTS INSURED AND EXPENSES REIMBURSABLE BY THE INSURER
29.1. The insured event for the Luggage risk, unless otherwise provided by the Insurance Contract, is:

29.1.1. loss of luggage officially handed over to the carrier for the period of the Insured Person’s transfer to the insurance territory and back, documented and confirmed as a result of the following events:
- natural disaster (the fact of which is confirmed by local competent authorities or published on the official websites of the competent authorities);
- fire, including exposure to water (foam) and other means used in fire extinguishing, lightning, explosion;
- theft of luggage;
- wreck, collision, overturning and other accidents with the vehicle on which the luggage was carried;
- loss of luggage;
29.1.2. the delay in luggage officially handed over to the carrier for the period of the Insured’s transfer to the insurance territory and back, due to the delay in the delivery of luggage or the transfer of luggage to another place for a period exceeding the time franchise stipulated in the Insurance Contract in the “Franchise” column. In the event that the Insurance Contract does not set a time limit for delaying the delivery of luggage by the carrier to the Insured Person, the time franchise is considered equal to 48 hours, provided that the specified events in paragraphs 29.1.1, 29.1.2 are not associated with and/or not caused by:

29.1.1) loss of luggage, which accompanies the Insured Person as a carry-on luggage, as well as luggage delivered to the carrier, without the latter having issued the relevant transportation documents;
29.1.2) loss of luggage, which contained explosive, poisonous and/or corrosive substances;
29.1.3) loss of useful properties of luggage due to the natural properties of materials, substances and items carried in the luggage (including but not limited to: wear, rust, mold, discoloration), special properties or natural qualities of the insured luggage, normal wear and tear, natural deterioration in quality, mold;

29.1.4) spoilage by insects and rodents;

29.1.5) surface damages and disturbances in the appearance of items of luggage (scratches, scrapes, etc.);

29.1.6) loss of items of luggage that require special storage and/or transportation conditions, due to non-compliance with these conditions;

29.1.7) non-fulfillment or improper performance by the Policyholder (the Insured Person) of its obligations associated with the carriage and storage of luggage, including payment, packing conditions and timely receipt of luggage;

29.1.8) improper (according to the norms of the current legislation of the Russian Federation) packing of items of luggage;

29.1.9) damage caused by the consumables, acids, paints, aerosols, drugs and any liquids carried in the luggage, as well as the damage caused by them;

29.1.10) loss of property (luggage) directly caused by pressure waves caused by airplanes or other airs moving with sound or supersonic speed;

29.1.11) loss of property (luggage) caused by precipitation (rain, snow, etc.);

29.1.12) confiscation of luggage by any public service;

29.1.13) compensation of expense:

   a) non-pecuniary damage;

   b) incurred by the Insured Person for compensation for harm to life, health and/or property of third parties from other persons, including Insurance companies and guilty persons;

29.1.14) loss of luggage, completely reimbursed on the basis of the Insurance Policy of another insurance company, as well as under the Contract of liability insurance of the carrier;

29.1.15) the occurrence of force majeure, such as war, military actions, as well as maneuvers or other military measures and their consequences, strikes, revolutions, insurrections, civil unrest, public disturbance of all kinds and riots; natural disasters and their consequences, epidemics, meteorological conditions, nuclear explosion, direct or indirect effects of radiation, radioactive or other types of infection, any types of emergency situations (catastrophes, etc.), and other force majeure circumstances, as well as cases provided for by the legislation of the Russian Federation:

29.1.16) terrorist acts and their circumstances;

29.1.17) the delay in luggage when transported by charter flights, if these flights are not included in the international booking system;

29.1.18) removal of an aircraft from flight by any civil aviation service.

29.2. For the Luggage risk, unless otherwise provided by the Insurance Contract, the expenses of the Insured Person:

29.2.1. caused by the destruction or loss of the luggage space officially handed over to the carrier;

29.2.2. related to the delayed luggage of the Insured Person during the insured trip for a period exceeding the deductible and within the insured sum specified in the Insurance Contract;
29.3. In the Insurance Contract, the parties may provide that exceptions to the insurance referred to in clause 29.1 paragraphs 1), 10), 13), 15) -18) of these Rules are included in the insurance (the Insurer pays the insurance indemnity for these circumstances), provided that the Insurance Contract (Policy) specifies in the column “Special Terms” the paragraphs included in the insurance.

30. SUM INSURED. INSURER’S LIABILITY LIMITS

30.1. The sum insured for the Luggage risk is established with the words of the Insured Person, unless otherwise provided in the Contract, and should not exceed the actual cost of luggage.

The insurance amount is indicated in the Insurance Contract.

The actual value of the luggage is the actual value of the property on the day of conclusion of the Insurance Contract.

30.2. The limit of liability of the Policyholder for the loss of luggage is established within the insured sum specified in the Contract for one luggage place for the entire insurance period, unless otherwise stipulated in the Insurance Contract.

30.3. The limit of liability of the Policyholder for the delay of luggage is established within the sum insured specified in the Contract for one luggage seat for each case of luggage delay officially handed over to the carrier for the period of the Insured Person’s transfer to the insurance territory and back, unless otherwise stipulated in the Insurance Contract.

30.4. The insurance amount for the Luggage risk can be set in the Contract in aggregate for two insurance events: in case of loss (death) of luggage and in case of delay in luggage. When concluding the Contract on such terms, the limit of liability for one luggage place for the entire period of insurance on the event loss of luggage is established within the total insurance amount of the Luggage risk insurance contract, the luggage liability limit is set at 10% of the total Insurance amount for the Luggage risk, unless otherwise provided by the Insurance Contract.

30.5. In the Insurance Contract, special limits of liability (insured sums) for certain types of events and/or franchise for one insurance event can be established.

31. OBLIGATIONS OF THE PARTIES UPON OCCURRENCE OF THE EVENT INSURED

31.1. Upon occurrence of events that have signs of an event insured, the Policyholder (the Insured Person/his/her representative) is obliged:

31.1.1. to perform the general duties provided for in clause 8.6 of these Rules;

31.1.2. to perform all actions and draw up the documents necessary for presenting the claim to the carrier, the responsible custodian, incl. draw up an act on the loss of luggage; file a claim with the carrier;

31.1.3. to apply to the authorized bodies (transport organizations, competent authorities) at the scene to obtain documents that record the loss of luggage (for example, a commercial certificate compiled by a representative of the carrier). The refusal of the said bodies to draw up the proper documents must also be made in writing.
31.2. Neglect of the requirements of paragraph 31.1 may serve as a basis for refusal in insurance payment or to reduce the amount of insurance payment in respect of not documented losses.

31.3. When applying for assistance provided by the Insurance Contract, the Policyholder (the Insured Person/his/her representative) is obliged, in addition to the information provided for in clause 8.6, to provide information on the actions taken by the carrier and the authorities in connection with the investigation of the circumstances of the injury.

31.4. If necessary, the Insurer has the right to demand from the Policyholder (the Insured Person) submission of written explanations and/or documents available on their hands. At the same time, the Policyholder (the Insured Person/his/her representative) is obliged to immediately forward the necessary documents to the Insurer in the manner agreed with the Insurer.

31.5. The Policyholder (the Insured Person) is obliged to submit to the Insurer an application for payment according to the form established by the Insurer. The application must indicate the nature and circumstances of the event that has signs of the insured event, the organization that formed the tourist group, if the trip was organized by a travel agency/tour operator. The application must be accompanied by originals or copies certified by a notary or in accordance with the procedure established by law (original payment documents), the following documents:

31.5.1. the Insurance Contract;
31.5.2. a regular passport or other document (only for foreign citizens or stateless persons), migration card, customs declaration, tickets and/or other documents;
31.5.3. documents confirming the transfer of luggage to the carrier (luggage tag);
31.5.4. documents transferred earlier to the Insurer in the form of copies in accordance with the requirements of paragraph 31.4. of these Rules;
31.5.5. ticket (boarding card);
31.5.6. claim to the name of the carrier’s company with a note on accepting the claim and other documents necessary for presenting the claim to the carrier filed during the time limit contained in the carrier’s transportation conditions;
31.5.7. statement for the police and a police notification of receipt of the application; the decision to open a criminal case/administrative violation upon theft/theft of luggage;
31.5.8. commercial document/other document drawn up by the carrier/representative of the carrier, fixing the loss of luggage, containing information on the number of places of lost luggage;
31.5.9. cash order warrant (other document) confirming receipt of a reimbursable compensation from the carrier and/or third parties;
31.5.10. a document confirming the fact of a natural disaster;
31.5.11. a document confirming the delay in luggage with the carrier’s mark, including the number of hours of delay, as well as a document confirming that the flight carrying luggage was not chartered and was included in the global distribution system.

31.6. The application must also be accompanied by the documents specified in clause 31.1 of these Rules.

32. PROCEDURE FOR MAKING INSURANCE PAYMENTS
32.1. The insurance payment is made to the Insured Person who is the owner of the luggage, in the amount of the insurance amount and the limits of compensation established in the Insurance Contract.

32.2. If the Insured Person has received compensation for lost luggage from third parties (including the carrier, another Insurance company, etc.), the Insurer pays the difference between the amount payable under the Insurance Contract and the amount received from third parties, regardless of the declared valid luggage cost. The Insured Person is obliged to inform the Insurer of the receipt of such sums.

<table>
<thead>
<tr>
<th>Codes of insurance programs for “Luggage” risk</th>
<th>A list of events insured according to the following paragraphs of these Rules</th>
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<tr>
<td>BR1</td>
<td>29.1.1.</td>
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<tr>
<td>BR2</td>
<td>29.1.2.</td>
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<tr>
<td>BR3</td>
<td>29.1.1., 29.1.2.</td>
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SECTION 6. INSURANCE FOR “CIVIL LIABILITY” RISK

33. PROPERTY INSURED
33.1. The property insured is the property interests of the Policyholder (the Insured Person) not inconsistent with the legislation of the Russian Federation, connected with the risk of liability for the damage to life, health and/or damage to third parties’ property while staying in the insurance territory specified in the Insurance Contract.
33.2. The “Civil liability” risk is considered to be the insured liability of the Policyholder and/or the Insured Person referred to in the Insurance Contract.
33.3. The Insurance Contract for the risk of liability for causing harm is considered concluded in favor of persons who may be harmed (the Beneficiaries).

34. EVENTS INSURED AND EXPENSES REIMBURSABLE BY THE INSURER
34.1. The event insured for “Civil Liability” risk, unless otherwise provided by the Insurance Contract, is an actual, sudden, unforeseen and unintentional event, as a result of which the Insured Person is obliged by reason of a court decision or in case of recognition by the Insured Person, with the written consent of the Insurer, caused by the Insured Person to the life, health of the third person(s) or the damage caused to the property of a third party (physical and/or legal body), not connected with:
34.1.1) admission of liability, offer or promise of payment made by the Insured Person without the prior consent of the Insurer;
34.1.2) responsibility arising from the owning/using of any means of transport (including carriage and transportation);
34.1.3) responsibility arising from the use of property in temporary possession, disposal, use by the Insured (including rent (lease, leasing), pledge, safe storage);
34.1.4) the emergence of responsibility arising from any willful act (omission) of the Insured, aimed at the occurrence of an insured event. Intentional harm is equated with the commission of an act or omission in which a possible loss is expected with a sufficiently high probability and is deliberately allowed by the person responsible for such actions;
34.1.5) responsibility arising from any professional activity of the Insured Person;
34.1.6) responsibility of close relatives of the Insured Person;
34.1.7) responsibility as a result of non-fulfillment or improper performance by the Insured Person of the obligations provided for under any agreements or transactions;
34.1.8) committing a purport act by the Insured Person, which can be qualified by the competent authorities as a criminal offense;
34.1.9) responsibility for an accident, bodily harm, death or illness of a person who is an employee or close relative of the Insured Person, or a person with whom the Insured carries on a joint trip. A joint tourist trip is understood as a trip made jointly with the Insured under one Contract on the sale of a tourist product, in which the time and place of residence (city, hotel, one hotel room) coincide, as evidenced by documents (tourist voucher, tourist voucher, travel documents, confirmation of hotel booking, bank statement of payment);
34.1.10) responsibility for the loss or damage of property belonging to or under the control of the Insured/his close relative or any person from his subordinates with whom the
Insured carries out a joint trip (except for loss or damage to property located in the premises temporarily occupied during the trip but not owned by the Insured);

34.1.11) responsibility for infection with any diseases and viruses;

34.1.12) responsibility for damage caused by permanent, regular or prolonged thermal influence or exposure to gases, vapors, rays, liquids, moisture or any, including non-atmospheric precipitation (soot, smoke, dust, etc.);

34.1.13) a claim for compensation for damage caused by infringement of copyrights, rights to discovery, invention or industrial design, or similar rights, including unauthorized use of registered trademarks, symbols and names;

34.1.14) claim prosecution for compensation for non-pecuniary damage, honor protection, dignity and business reputation;

34.1.15) any event that occurred when the Insured Person was under the influence of narcotic or other intoxicating substances (including offenses, traffic accidents that occurred during the driving by the Insured Person any vehicle);

34.1.16) any event that occurred while the Insured Person was in alcoholic intoxication (including offenses, accidents that occurred during the driving by the Insured any vehicle);

34.1.17) driving vehicle by the Insured without a legal basis for its using, including the lack of rights to drive a vehicle of the appropriate category;

34.1.18) Insured Person’s flight on any type of aircraft (non-motorized, motor gliders, paragliders, ultralight vehicles, etc.), operating it, except in cases of flight as a passenger on a civil aviation aircraft of a conventional or charter flight operated by a professional pilot;

34.1.19) occupation of the Insured Person by any type of work, including but not limited to performing any work that increases the likelihood of an insured event, both as a professional and unprofessional activity: a driver of a vehicle, a miner, an electrician, a miner, a pilot, performing subversive, construction and agricultural works, work at height, with moving mechanisms or electrical appliances;

34.1.20) fulfillment by the Insured of any type of professional work not provided for under the terms of his Employment Agreement (contract);

34.1.21) the occurrence of an event insured through the fault of the employer of the Insured Person;

34.1.22) service of the Insured Person in the armed forces of any state and any formations;

34.1.23) compensation of expenses, which, in accordance with the court decision that came into force, the Insured Person is obliged to incur compensation for non-pecuniary damage and/or loss of profit caused to third parties;

34.1.24) compensation of expenses that were incurred in order to protect the interests of the Insured Person and the Policyholder without the Insurer’s consent;

34.1.25) the occurrence of force majeure, such as war, military actions, as well as maneuvers or other military measures and their consequences, strikes, revolutions, insurrections, civil unrest, public disturbance of all kinds and riots; natural disasters and their consequences, epidemics, meteorological conditions, nuclear explosion, direct or indirect effects of radiation, radioactive or other types of infection, any types of emergency situations (catastrophes, etc.), and other force majeure circumstances, as well as cases provided for by the legislation of the Russian Federation;

34.1.26) terrorist acts and their consequences;
34.1.27) an injury got during the Insured Person’s going in for any kind of sport and participation in training and sporting events, participation in competitions of athletes on a professional or amateur level, and also any active rest, except for the Insurance Contracts with the condition “Sports” reflected in the column “Special Conditions” of the Policy according to clause 3.4.1 of these Rules;
34.1.28) compensation of expenses:
   a) non-pecuniary damage;
   b) in the event that the Insured Person receives compensation for harm from other persons, including the Insurance companies and the perpetrators.

Insurance coverage extends exclusively to insured events that occurred during the term of the Insurance Contract. If the insured event that occurred during the term of the Insurance Contract occurred due to the reasons that took place or started before the insurance commencement date, the insurance indemnity is payable only if the Insured has not been aware of anything and nothing should have been known about the reasons that led to the onset of this insured event.

34.2. The “Civil Liability” risk is subject to reimbursement of the following necessary and documented expenses directly related to the insured event:
   34.2.1. expenses that the Insured Person is obliged to incur in order to compensate for actual damage caused to third parties.

Real damage is understood as expenses that a person whose right has been violated, has or will have to do to restore the violated right to lost and/or damaged property, as well as expenses to cover the harm caused to his life and health, as follows:
   34.2.1.1. direct real damage caused to a third party as a result of damage (destruction), loss of property belonging to a third party on the rights of ownership (or on the basis of a legally documented legal obligation), within the real value of the property or the cost of its restoration (repair);
   34.2.1.2. real damage due to harm to life and health of individuals, determined by the laws of the insurance territory (places of damage);
   34.2.1.3. necessary and expedient expenses for saving lives and property of persons who, as a result of an insured event, caused harm to health, as well as to reduce harm and damage caused by an insured event;
   34.2.1.4. if this is stipulated in the Insurance Contract:
      a) expedient costs for the preliminary clarification of the circumstances of the occurrence of the insured event and the degree of guilt of the Policyholder (the Insured Person);
      b) the costs of conducting cases in the judicial bodies on the alleged cases of harm.

34.3. In the Insurance Contract the parties may provide that exceptions to insurance specified in clause 34.1. paragraphs 2), 3), 5), 14), 16), 19), 21), 25) -27) are included in the insurance (the Insurer pays an insurance indemnity for the above circumstances), provided that the Insurance Contract (Policy) specifies in the column “Special Terms” the paragraphs included in the insurance.

35. SUM INSURED. INSURER’S LIABILITY LIMITS
35.1. The sum insured for “Civil Liability” risk is established by agreement of the parties and is specified in the Insurance Contract.
35.2. The total sum of payments for the Civil Liability risk may not exceed the sum insured.

35.3. In the Insurance Contract, liability limits may be established for certain categories (items) of expenses, in particular:
   35.3.1. limit of liability for expenses for compensation of harm to life and health of third parties;
   35.3.2. limit of liability for expenses related to compensation of damage to property of third parties;
   35.3.3. limit of responsibility for the costs of protecting the interests of the Insured in the civil proceedings.

35.4. in the Insurance Contract an unconditional franchise for certain types of insured events and/or certain categories (items) of expenses can be established.

36. OBLIGATIONS OF THE PARTIES UPON OCCURRENCE OF THE EVENT INSURED

36.1. In the event that may serve as the basis for making claims to the Insured Person by third parties for compensation of the damage caused to them, the Insured Person (his/her representative) and/or the Policyholder are obliged to fulfill the general duties stipulated in item 8.6. of these Rules, and additionally:
   36.1.1. immediately, within no more than 24 hours from the moment of bringing charges, claims, etc., to notify the Customer Service about any incident in any accessible way allowing objectively to fix the fact of the message and to comply with all instructions of the Customer Service;
   36.1.2. if the Insured Person has information about the upcoming charge, investigation, he must immediately notify the Insurer or the Customer Service;
   36.1.3. in the event that the Insured Person, by virtue of circumstances, is unable to contact the Customer Service or the Insurer, he may entrust it to his representative;
   36.1.4. without the written consent of the Insurer or the Customer Service not to make any promises either in writing or verbally and not to make proposals for voluntary compensation of the losses incurred, not to recognize all or part of their fault (responsibility), not to pay any sums for compensation for harm, not to give promises of payment or to discuss the terms of any claim without the written consent of the Insurer.

If the requirements of this paragraph are not fulfilled, the Insurer has the right to refuse insurance payment.

36.2. When applying for assistance provided by the Insurance Contract, the Insured Person (his/her representative) and/or the Policyholder is obliged in addition to the information provided for in clause 8.6 of these Rules, to provide the information about:
   36.2.1. nature of damage caused to third parties;
   36.2.2. actions taken by the participants involved in the settlement of the insured event, and by the authorities on the fact of causing harm.

36.3. Upon receiving of the occurrence notification of events specified in paragraph 34.1, the Insurer makes a decision on whether it is expedient to perform any actions on its part and the Customer Service to protect the interests of the Policyholder (the Insured Person).
36.4. If necessary, the Insurer and/or the Customer Service has the right to require the Insured Person or the Policyholder to provide written explanations and/or documents in their possession. In this case, the Insured Person (his/her representative) and/or the Policyholder is obliged to immediately forward the necessary documents agreed with the Insurer (Customer Service) in the way.

36.5. When receiving any claims, demands, subpoenas, invitations to examinations and other documents from third parties and/or competent authorities related to the fact of causing harm, the Insured (his/her representative) and/or the Policyholder is obligated immediately within 24 (twenty four) hours to notify the Insurer and/or the Customer Service about the phones specified in the Insurance Contract and forward the received documents via facsimile or electronic communication to the number and/or electronic address determined by the Customer Service.

36.6. When making a court decision on the case of harm to third parties, the Insured Person (his/her representative) and/or the Policyholder must immediately notify the Insurer and/or the Customer Service about the phones specified in the Insurance Contract within 24 (twenty four) hours and forward the available phones Documents to the specified number and the transfer method specified by the Customer Service.

36.7. If the Insurer considers it necessary to appoint his lawyer or other authorized person to protect the interests of both the Insurer and the Policyholder (the Insured Person), provide the determined person with all the information and documentation listed in clause 33 and issue a power of attorney for the right to represent the interests of the Policyholder (the Insured Person) in court.

In the process of conducting business proceedings on the fact of causing harm, the Policyholder (the Insured Person) and authorized representatives are obliged to follow the instructions of the Insurer and/or the Customer Service, if such instructions have taken place.

36.8. If the failure to perform or improper performance by the Insured or the Insured Person of their obligations specified in clause 36 of these Rules, including in terms of information terms, resulted in an increase in losses from the insured event, the Insurer has the right to refuse part of the losses caused by improper performance by the Insured Person or the Policyholder of their obligations.

36.9. To receive insurance payment, the Insured (the Policyholder) is obliged to submit to the Insurer not later than 30 (thirty) calendar days from the date of occurrence of the insured event application for payment in accordance with the form established by the Insurer, with originals or copies, certified by a notary or in accordance with the procedure established by law, the following Documents (original payment documents):

36.9.1. the Insurance Contract;
36.9.2. a regular passport or other document (only for foreign citizens or stateless persons);
36.9.3. the court decision that came into force on the compensation of harm to third parties in the event that the case of compensation for harm was settled in court;
36.9.4. documents previously transferred to the Insurer and/or the Customer Service in the form of copies or by facsimile or electronic communication;
36.9.5. written explanations of circumstances and other documents necessary to confirm the fact of the insured event and the amount of losses incurred (damage caused);
36.9.6. bills for telephone calls with the Customer Service on the phone numbers specified in the Insurance Contract.

36.10. The Insurer also has the right to independently request information necessary for resolving the issue of insurance payment in judicial and other competent authorities at the place of injury.

37. PROCEDURE FOR MAKING INSURANCE PAYMENTS

37.1 Insurance payment is carried out:

37.1.1. If the Policyholder (the Insured Person) in accordance with the established procedure has informed of the occurrence of the insured event and has complied with all the requirements provided for in clause 36 of these Rules, taking into account clauses 34 and 35 of these Rules;

37.1.2. to the injured third person, and in case of his/her death – to the heirs, in the part of the sums due to compensation for harm to life, health and property of a third party;

37.1.3. if the Policyholder (the Insured Person), with the written consent of the Insurer, independently regulates the claims of third parties, the insurance indemnity is paid to the Policyholder (the Insured Person) provided that documents confirming the production expenses and costs are submitted;

37.1.4. to the Policyholder (the Insured/a person whose liability is insured), in the part of expenses on harm reduction and legal expenses;

37.1.5. In the amount of the difference between the amount subject to reimbursement to third parties under the Contract (Policy) and the amount compensated by other persons, if the damage caused as a result of the insured event is compensated by other persons (including under the Property Insurance Contracts).

37.2. If the recipient of the insurance payment is a third party, the procedure and form of the insurance payment are determined by agreement between the Insurer and the third person who was harmed. The Insured Person (a person whose liability is insured) has the right to obtain from the Insurer all information concerning the procedure and form of insurance payment to a third party.

<table>
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