GENERAL CONDITION

ARTICLE 1. INSURANCE POLICY

The General Conditions of the Insurance Contract, Annexes, Insurance Policy, written declarations and applications forms, for the purpose of this contract, shall be considered as Insurance Contract.

ARTICLE 2. INSURANCE OBJECT

According to this insurance contract, the insured person is covered for the risks specified at the 'Benefits Table'.

ARTICLE 3. DEFINITIONS

The following words shall have this meaning for the purpose of this contract:

Insurer	Sigma Interalbanian – Vienna Insurance Group, Insurance Company
Policyholder	The person who signs the insurance policy.
Insured	The person who is covered by the insurance policy.
Premium	The amount of money paid by the policyholder for the insurance within agreed specified deadlines.
Sum assured	The maximum limit payable by the Insurer during the insurance period, for each benefit, treatment or medical care covered by this insurance policy, despite the limits defined at each section or annex.
Annex	Any annex to the policy, which acts according to the general and special conditions, the relevant additional acts which provides additional insurance coverage.
Hospital institution	Any medical institution, which has the due license for medical treatments or surgical interventions, where the patients are continuously under the medical supervision. Medical centers that provide services for persons who need prolonged and continuous recovering services, relaxation or rehabilitation centers, and institutions for old people or disabled persons are not considered as hospital institution.
Sickness or disease	Unintentional deterioration of any health condition and any abnormality which occurs to the function of the organs of the insured body, independently by the insured's will, due to pathological changes and it can be diagnosed by a doctor.
Accident	Any body injury caused solely by violent, accidental, sudden, external and visible events, independently by the insured will.
Waiting Period	The period from the beginning of the policy, during which no medical expenses are paid, except accidental or emergency expenses.

Hospitalization	Is considered the treatment that must be received in a hospital institution and the insured must be hospitalized at least 1 (one) night. It is not considered a treatment, the hospitalization of the insured for periods longer than necessary, or if no pathological condition was diagnosed.
Doctor	Any licensed practitioner, who has the due diploma in medicine according to national or international standards.
Preexisting Conditions	Any sickness, disease or injury, which was diagnosed by a doctor or which required a medical treatment including drugs prescription, or diseases or sickness which gave symptoms before the health insurance went into effect, despite it was diagnosed or not.
Chronic Condition	A sickness or injury, which has at least one of the following characteristics: • If it persists for an undefined period and no known cure is prescribed. • When it recurs or there are chances to recur. • It is persistent • A rehabilitation is required or the assistance of trained people to live with the person. • Prolonged supervision, medical controls, examinations or tests are required.
Medical Emergency	Acute deterioration of the health condition due to the accident that poses an immediate risk to a person's life or health, such as loss of conscience, hard breathing, poisoning, serious hemorrhage, chest pain related to heart diseases, etc.
Percentage and refund	The specified percentage of coverage for specific medical treatments, defined at the Table of Benefits that the insurer must refund to the Insured.
Medical Evacuation	The service of a licensed road ambulance from the place of the accident to receiving medical facilities, or emergent transfers between hospitals, if the required medical treatment cannot be provided by the present hospital, and it is advised by the responsible doctor.
Day Surgery	Shall be considered a surgery in a medical center that does not require a stay for more than 24 hours.
Medical Treatment	Any scientifically accepted treatment, applied with approved protocols, with the aim to improve or preserve the health of the insured, according to the medical advice and recognized as medical treatment by the authorities.
Diagnostic Tests	Necessary microbiological and biochemical tests, necessary examinations to diagnose and follow up

	of medical treatments performed by the insured, such as X-Rays, Ct Scan, MRI, Pet Scan, etc.
Drugs or medicines	Preparations prescribed by a doctor which are finished products and represent a chemical substance or combination of the chemical substances, with the purpose to treat a disease, or give a prophylactic treatment. Nutritional supplements, weight management products, stimulants, hormones and other doping substances, tonic products, fish oil, cosmetic products, contraception products, baby food and other baby products shall not be considered drugs or medicines.

ARTICLE 4. EFFECTIVINESS OF THE INSURANCE CONTRACT

1. The insurance policy shall become effective with full rights at 24.00 of the beginning date specified at the policy, provided that the insurance premium or instalment has been paid to the Insurer.
2. The insurance contract shall become effective with full coverage after the waiting period of 60 days for persons which are insured for the first time with this insurance contract. Shall be covered the expenses due to accidents or medical emergencies.
3. The insurance contract shall be in force for a period of 12 months, renewable with a tacit acceptance procedure for other 12 months, provided the insurance premium is paid.

ARTICLE 5. BINDING THE INSURANCE CONTRACT

1. The Insurer must complete and sign the application form regarding his health conditions and must answer accurately and precisely. The application form shall be part of the insurance contract.

2. The insurer has the right to check the health condition of the Insured, including medical examinations from the authorized doctor by the Insurer. The persons insured for the first time with this insurance contract, the medical health conditions shall be evaluated through the check up performed during the first 30 days of the beginning of the policy and payment of the premium.

3. If the check up reveals a higher risk than the standard, the Insurer reserves the right to provide a different coverage or to reject it, by returning the insurance premium according the actuarial calculations.

4. The information received by the Insurer regarding the Insured health conditions, shall be fully confidential and shall be used solely for contracted purposes between parties. The Insured releases from the professional secrecy act any doctor, medical clinic or hospital institution that has information about the health of the Insured. This information shall be given to the Insurer, before and after the insurance event occurs.

ARTICLE 6. INSURED PERSONS

The persons from 18 – 60 years of age, resident in Albania during the insurance period and who meet the underwriting requirements, are eligible for the purpose of this insurance contract.

The persons who seek persistent medical care, or their living formally requires the third parties care, or have alcohol or drugs addiction, cannot be insured under the conditions of this contract.

The persons that are (or will be) 60 years old during the first year of the insurance, shall not be eligible for this contract.

ARTICLE 7. MEMBERS OF THE FAMILY

Provided that the contracting parties agree, insured persons shall also be considered members of the family who depends by the Insurer and shall be limited in:

- Spouse or partners – up to 60 years old;
- Children from 30 days to 17 years old, or up to 25 years if they are still attending the university and are not married.

The coverage of family members is subject to the same terms and conditions, deadlines and annexes of the insured.

Partner shall mean the person to which the insured is not legally married, but lives with, and/or have unmarried children, including children that live with the insured as part of the family.

The Insurer must submit the required medical information regarding the health of family members that depends from him, when they are minor, signing the relevant application forms. Whether they are considered eligible or not for this contract, it shall be evaluated by the insurer, which shall give a written reply to the Policyholder.

ARTICLE 8. INSURANCE PREMIUM

The annual premium is paid annually or with two installments. The premium shall be paid at the account of the Insurer. The first installment cannot be less than 50%.

The delay in paying an overdue premium installment gives the company the right to cancel the contract.

The Insurer gives the right to the insured, to a period of 15 days delay. This period shall not be applied for the first premium payment or installment. During this period the policy shall be in force with full rights, and if the premium is not paid by the end of this period, the policy shall be canceled and the last day of the coverage shall be considered the day of the premium payment.

The Insurer has the right to change the premium when the contract is renewed. In this case, the Insurer must notify the policyholder or the insured for the new conditions, 15 days before the termination of the insurance contract. The Insured or the policyholder must give a written notice to the Insurer for the acceptance of the new insurance conditions and the renewal of the contract, before the termination of the contract.

ARTICLE 9. TERMINATION OF THE INSURANCE CONTRACT

The contract can be considered terminated:

1. When the Insurer find facts of the nature that if they would have been known before the beginning of the insurance, thy would have been the cause of rejecting such coverage;
2. When the insurance premium has not been paid;
3. When the Insured reaches the age limit of 60 years old.
4. At any other date if the underwriting conditions has not been met;
5. When the limit of maximum Insurance Sum has been reached.

The insurance contract can terminate upon the written request of each party; anyway, the termination shall be effective one month later.

The issue, termination or modification of the terms of the Contract, shall be done solely by the Insurer. A prior approval of the Policyholder is required for this purpose, but not the approval of the Insured or beneficiary. The change in insurance limits required by the policyholder shall be effective only after the written approval of the Insurer and the additional premium payment.

ARTICLE 10. WAITING PERIOD

All the individuals that shall be insured for the first time with this insurance policy, the waiting period of 60 days shall be applied, excluding the following:

- Expenses arising from emergencies or accidents.
- The insured shall be transferred from a group insurance policy to individual insurance policy.
- Renewals, except when there is a delay of more than 45 days from the termination date of the previous contract.

The following conditions shall have a waiting period of 12 months:

1. Discal Hernia.
2. Heart ischemic conditions, surgical cardiac and vascular interventions.
3. Conditions related to ovaries, uterus and breast, which require surgical interventions.
4. Surgical treatment, chemotherapy, radiotherapy for the cancer treatment.
5. Surgical treatment for the gallbladder, urinary and renal tract.

ARTICLE 11. COVERAGE FROM THIRD PARTIES

1. In cases when the insured applies for an indemnity which is covered even by another insurance policy, the Insured shall be liable only for the part of the indemnity calculated in pro rata bases.

2. If the insurance applies for reimbursement of payments which are covered by projects or programs financed by the government, the Insurer shall not be liable for the coverage.
3. The policyholder and the Insured must give notice to the Insurer and shall do whatever necessary for the indemnification and to protect the interest of the Insurer; in any case, the insurer shall have full rights for refund.

ARTICLE 12. COVERAGE AREA

Coverage area is considered the zone in which the insurance can receive medical treatment. Based on the coverage plan, the insured is covered 100% for the expenses within Albanian territory and 70% abroad.

ARTICLE 13. COMPETENT COURT

For any dispute between the Policyholder and/or any other interested party and the Insurer, Tirana District Court is the only body authorized to settle it.

ARTICLE 14. DUTIES, TAXES, OTHER CHARGES

Any present or future tax on behalf of third parties, regarding the insurance policy, shall be in charge of policyholder, insured or beneficiary.

ARTICLE 15. NON BINDING DOCUMENTS

The Insurer is bound only by documents that are signed by authorized persons or its legal representatives. No one else is entitled to sign or modify insurance policies on behalf of the company or to accept declarations or legal documents.

ARTICLE 16. HEALTH INSURANCE BENEFITS

The Insurer is liable for all the medical expenses, which are covered by the insurance contract and incurred within the insurance period, according to the Benefits Table.

Hospitalization Benefits

The insurer is liable to pay 100% of the expenses due to hospitalization that requires at least an overnight stay, as follows:

- Costs for semi private room and boarding. Personal expenses like telephone calls, television or the assistance of an interpreter shall not be reimbursed.
- Fees for surgeons, physicians, specialists, anesthetists.
- Cost for materials and theatre rent
- Diagnostic tests, examination as X-rays, CT scanner, MRI, PET scanner, scanner, ultrasounds.
- Treatment in the emergency room;
- Intensive Care.
- Drugs and medicines used in hospital as well as blood plasma and oxygen;
- Prosthetics and similar medical equipment.

The Insurer covers the accommodation expenses in a hospital institution of the parent or the custody person if the hospitalized insure is minor less than 8 years old and if required by the doctor.

The maximum covered hospitalization is for a period of 90 days.

Outpatient Benefit

According to the general and special terms and conditions, the Insurer is liable to pay the medical expenses which do not require hospitalization, up to the limits specified at the benefits table;

- Expenses for consultation with General Practitioner
- Costs for physician specialist and diagnostic tests recommended by the doctor.
- Expenses incurred for the purchase of medicines as prescribed by the doctor for the necessary treatment
- Day surgery as an outpatient;
- Diagnostic tests and examinations with RXT, CT scanner, PET scanner MRI scanner, scans, scintigraphy.

Preventive care, which includes the Check-up tests, shall be specified at the benefits table. The inured has the right to an annual checkup. For the first year of the insurance policy, the checkup must be completed the first month of the beginning of the contract.

Road Ambulance Transport

In case of an emergency, the Insurer is liable for the cost of a road ambulance to transport the Insured from the place of the accident to receiving medical facilities or emergent transfers between hospitals, if the required medical treatment cannot be provided by the present hospital.
Air Ambulance is not covered by this policy.

Accidental Dental Care

The Insurer is liable for the expenses up to the specified limit at the Table of Benefits, for emergency dental care treatments, to repair or replace the damaged teeth as a result of an injury due to an accident. Treatments must be received within 48 hours from the moment of the accident. Expenses incurred as a result of accidents occurring during chewing or injuries due to the placement of any object in the mouth are not covered.

Radiotherapy and chemotherapy

The Insurer is liable for the expenses up to the specified limit at the Table of Benefits, for radiotherapy and chemotherapy.

ARTICLE 17. GENERAL EXCLUSIONS

This policy does not cover the expenses caused or contributed directly or indirectly by:

a) Preexisting disease, disabilities, structural irregularities, that existed before the beginning of the insurance period, and the Insured or Policyholder knew about it at the moment they signed the application

form, except if the Insurer gave a special written acceptance for the coverage.

b) Sickness or disease, which are known or unknown by the Insurer, or that are firstly diagnosed during the waiting period or the first Check Up of the Insured, for the first year of the insurance policy.
c) Examination or treatment of the congenital diseases, genetic, refractory abnormalities, growth complications, even if diagnosed in later periods.
d) Psychiatric diseases, epilepsy, Parkinson, Alzheimer and other geriatric diseases, including psychotherapy.
e) Cosmetic Surgery, only if necessary due to an accident, diet and weight management treatments, massage, acupuncture, homeopathic treatments, hydrotherapy, mesotherapy, cosmetic and dermatological care.
f) Medical problems or injuries that incur during the exercise of professional or amateur hazardous sports (mountain climbing, diving, rock climbing, parachuting, bicycle sports, car race, athletic races, driving a motor vehicle in a race or speed competition, private aviation, extreme sports).
g) Any kind of corrective surgery due to doctor's or medical institution malpractice.
h) Any examination or dental treatment or surgical dental intervention, expect when due to an accident.
i) Costs for finding and transporting the organs for transplant and the medical expenses of the donor.
j) Professional and infective disease which are officially known by the authorities.
k) Routine tests, diagnosis, visits, treatments, which are not related to health problems, prophylactic treatments and vaccinations, (except tetanus and rage), if the policy does not have a special coverage.
l) Vitamins or mineral combinations, contact lenses, oral contraceptive, hair loss and /or dandruff solutions, powder, medical liquids with fruit base, artificial sweetener, herbal fibers, herbal medications, medical tea, products for the oral care, diapers, baby formula, feeding bottles, nipples.
m) Allergy treatment and diagnose. Immunotherapies.
n) Sexually transmitted diseases, diagnosis, tests and treatments for HIV, AIDS, infertility, procedures and anything related to sexual transformations, sexual malfunction. Diseases that are related to alcohol and/or drugs addiction.
o) Childbirth or complications, abortion, and in general any situation related to the childbirth or its complications, except when specified differently at the Table of Benefits.
p) Sclerotherapy for superficial varicose veins. Multiple sclerosis, Systemic Lupus Erythematosus.
q) Parietal deviation and nasal surgery; ear snail.
r) Examination and treatment of the menopause and osteoporosis and other related conditions.
s) Costs for optical test and radial keratome surgery in case of myopia, astigmatism, hypermetropia or presbyopia
t) Hemodialysis, blood transfusion, renal insufficiency.
u) Self-infliction of the insured, suicide and any other similar act, (being mentally sane or not);

In cases when the insured has been covered by this policy for more than 5 years, the exclusions “m” “ p” ,”t”, shall not be applied.

ARTICLE. 18 CLAIMS PAYMENT AND COST REFUND
The procedure to be followed in case of a claim or cost refund is as follows:

a) Prior Approval
The insured must have a prior approval for the following cases:

- Hospitalization
- Advanced Imagery tests (CT Scanner, MRI, Pet Scan, Colposcopy)
- Computerized Axial Tomography (CAT)
- Coronarography
- Day Surgery

Written prior approval is necessary from the Insurer, after all the necessary medical supportive documents are sent with the medical report and cost estimation. The Insured must reply within 4 working days for hospitalization cases and within 2 days for other cases.
If there is not a prior approval, the Insurer reserves the right to reimburse only 70% of the claim, if the treatment is covered by this policy.

b) ***Medical treatment out of Sigma Interalbanian VIG hospital network***
The medical service covered by the insurance contract and received in a hospital institution which is not at the Sigma Interalbanian VIG network, shall be covered 100%.

Hospital network of the company shall include all the hospital institutions contracted by the company to provide medical service to the insured persons.

In case the Insured decides to receive the treatment in a public hospital, he shall be reimbursed at 50% of the value of this intervention at the American Hospital, Tirana.

c) Medical treatment abroad
The insurer is liable to pay the medical treatments or surgical interventions abroad up to 70% of the coverage, according to insurance scheme at the Table of benefits. In any case, a prior approval is required. If the Insured fails to do so, the Insurer shall reimburse the value of this treatment in one of the private hospitals in Albania.

For the treatments abroad, all the submitted documents must be original copies, and if required they must be legally translated by the Insured. In case of accidents, the legal documents regarding the event must be submitted to the Insurer.

d) Reimbursement procedure and claims procedure

1. The claim application form should be submitted to the Claims office. For the children under 18 years of age, this form must be completed by the parents or their legal custody.

2. The insured must submit detailed invoices and medical recommendations for the received services and treatments. The invoices and medical report must be original and according the legal requirements of the authorities and taxes, otherwise no reimbursement shall be made.
3. The reimbursement for the medicines shall be made upon the presentation of doctor prescription. A photocopy of the prescription and the legal invoice is required.
4. The request for the cost reimbursement shall be submitted to the Insurer, not later than 30 days from the date of the invoice, or the date of treatment, whichever shall be first. The cost for the translation of the documents shall be in charge of the Insured.
5. After the necessary documents have been submitted to the claim Office, the Insurer shall reply or reimburse according to the General Conditions of this policy, within 30 days.
6. The reimbursement shall be transferred to the bank account of the Insured at the currency specified in the insurance policy, or other currencies if agreed.
7. If a claim is partially or totally rejected, the Insurer must give a written notice specifying the reasons of this decision.
8. Despite the documents specified above, the insured must submit to the Insurer other documents that verify the occurrence of the insurance event if required by the Insurer.

ARTICLE 19. REASONABLE AND ORDINARY COSTS

1. If the Insurer believes that the cost of the treatment are not reasonable for such a treatment at the country where they were received, the level of reimbursement shall be limited to the medical costs and the time of hospitalization that is common for the country where the Insured receives such a treatment.
2. A reasonable and ordinary cost is considered the payment for a service that has been paid before, or that has a specific price in the relevant country or that is offered by a similar professional, whichever is lower.

ARTICLE 20. MEDICAL EXAMINATION

The insurer has the right that with its own expenses to hire a doctor to examine any person that is covered by the contract, during the hospitalization or later. In case the insured refuses this medical examination, the Insurer shall not be liable to indemnify the Insured.

ANNEX
PERSONAL ACCIDENTS INSURANCE

ARTICLE 1. DEFINITIONS

The following words shall have this meaning for the purpose of this contract:

Insurance Event/case	Death or disability of the insured caused by unfortunate, unexpected, violent, unintentional, external, that do not depend by the will of the insured.
Total permanent disability	Total loss of the insured ability to work in their own or any occupation, caused by the accident, and proved by the competent authorities, after a period of 52 weeks from the beginning of the disability.
Partial permanent disability	Partial loss of the ability to work, caused by the accident, and resulting in anatomical loss of a limb or an organ of the Insured.
Loss of a Limb	Physical or functional loss of a hand, at or above the elbow articulation, or a foot, at or above the knee articulation.
Beneficiary	The physical or juridical person that benefits the sum insured, based on the Insured Will specified at the policy, in case of the accidental death of the insured. If the insured has not specified the beneficiary at the policy, then it shall be decided by the local court, according the legal disposition on the inheritance.

ARTICLE 2. THE RIGHT TO BE INSURED

The persons eligible to be insured with this contract, are up to 60 years of age, do not require permanent medical treatment and do not need third parties to support their livings. The insured that reach the age limit during the insurance contract, shall be insured until the end of this policy.

ARTICLE 3. DEFINITION OF ACCIDENTS

This annex covers the accident as described at the general conditions of the policy, which causes direct, visible, provable, body injuries, which are the exclusive and direct cause of death or total permanent disability of the insured.

ARTICLE 4. BENEFICIARY

The beneficiary is specified by the Insured. The replacement of the Beneficiary will be valid from the date of the written request of the Insured. If the beneficiary dies at the same day with the Insured, and no other beneficiary has been specified, the Insured sum shall be paid to the legal inheritors of the Insured.

ARTICLE 5. THE BENEFIT FOR THE ACCIDENTAL DEATH

In case of accidental death of the insured, not later than 12 months from the date of the accident, the Insurer shall pay to the beneficiary the Accident Insurance Sum specified at the Table of Benefits.

ARTICLE 6. INDEMNITY FOR TOTAL PERMANENT DISABILITY

Total permanent disability because of the accident, is the disability because of which the Insured shall be disabled to work in their own or any occupation, for the rest of his life. The insurer shall pay to the Beneficiary the insurance sum for Total Permanent Disability specified at the table of benefits.

For the purpose of this police, total permanent disability shall be considered:

- Loss of sight in both eyes.
- Anatomical or functional loss of at least 2 limbs (hemiplegia, paraplegia).

ARTICLE 7. INDEMNITY FOR PARTIAL PERMANENT DISABILITY

Partial permanent disability because of the accident is the disability because of which the Insured shall be partially disabled to work, for the rest of his life. The insurer shall pay to the Beneficiary the indemnity in percentage to the insurance sum, according the following table:

	RIGHT	LEFT
Loss of whole arm or hand	60%	50%
Loss of the whole shoulder movement	25%	20%
Total loss of movement of the whole elbow or the wrist	20%	15%
Total loss of thumb and index	25%	20%
Total loss of 3 fingers other than thumb or index	20%	15%
Total loss of thumb and one finger other than index	18%	16%
Total loss of index and one finger other than thumb	14%	12%
Total loss of thumb	20%	15%
Total loss of index	14%	12%
Total loss of middle or ring or small finger	8%	6%
Total loss of ring finger and small finger	15%	12%
Partial amputation of the leg or all his/her fingers	40%	
Loss of the whole leg or whole foot	60%	
Fracture of leg or foot which did not close and returned to its normal condition	25%	
Fracture of the kneecap which did not close and returned to its normal condition	20%	
Fracture of the tarsus which did not close and returned to its normal condition	15%	
Total loss of movement of knee or hip	20%	
Total loss of the big toe of foot	5%	
Total loss of a toe other than the big toe	3%	
Shortening of leg for at least 5 cm	15%	
Loss of vision of one eye or reduction of vision of both eyes	25%	
Total and incurable deafness of one ear	10%	
Total and incurable deafness of both ears	40%	
Fracture of lower jaw which did not returned to its normal condition	25%	
Anchyloses part of spine together with deformation	40%	
Fracture of ribs with deformation of thorax and organic abnormalities	20%	

If the insured is leftie, and this has been declared to the company, the percentages for the left limbs are valid for the right limbs, and vice versa.

In case of anatomical or functional loss of an organ or injured limb before the accident, the percentage in the table shall be deducted considering the level of the previous invalidity.

In case of physical or functional losses of more than one limb at the same accident, and they do not cause the total permanent disability, the total indemnity for all the limbs cannot be more than 80% of the insured sum for the disability.

ARTICLE 8. EXCLUSIONS

This annex does not cover:

- The disability of the insured or body injuries that existed before the beginning date of this policy and its complications, and even the accidents that are a consequence of a preexisting disability of the Insured.
- The accidents of the insured person while under narcotic drugs, tranquillizers, stimulants, strong alcoholic drinks.
- An accident due to enemy entry, war or civil war, rebellion and civil commotion's to which the insured has been actively involved.
- Suicide or attempt thereof, irrespectively of the insured's mental condition, or similar acts of the policyholder or beneficiary toward the insured.
- Accidents due to the insured's participation in events, acrobatic acts, dangerous sports activities as for example boxing, martial arts, scuba diving and mountain climbing.

ARTICLE 9. CASE OF INDEMNITY ACCRUALS

If, by an accident there will be a case in accordance with the present endorsement of accrual of indemnities, on the basis of the benefits of the present endorsement, due to the same cause, the insurer is obliged to pay only the highest claim.
If after the payment of the indemnity of whatever benefit of the present endorsement arises a demand for indemnity from another higher benefit of the present endorsement, the company shall pay in addition the difference of the amount, incorporating the two benefits. Physical damages, complications or corrective interventions after one year of the accident, are considered as sickness.

ARTICLE 10. PAYMENT OF INDEMNITIES

The indemnities provided by the present endorsement are paid to the policy holder or to the specified beneficiaries. The payment will be received at the company's Headquarters, Claims Office or transferred to the bank account of the beneficiary, after all the necessary documents for the claim settlements have been submitted.

ARTICLE 11. POLICYHOLDER/ INSURED LIABILITIES

The policyholder is liable to give a written notice to the Insurer within 4 days for every accident covered by this policy.

The policyholder, the insured or the beneficiary, must present to the Insurer or beneficiary, in case of accident any necessary information and must allow any investigation or examination related to the accident that is considered reasonable from the Insurer.

The expenses to prepare the documents are in charge of the policyholder, Insured or the beneficiary.