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triglav

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THE GENERAL TERMS AND CONDITIONS OF VOLUNTARY HEALTH INSURANCE

INTRODUCTORY PROVISIONS

Article 1.

These General Terms and Conditions of Voluntary Health Insurance (hereinafter referred to as the General Terms and Conditions) constitute an integral part of the Agreement on Voluntary Health Insurance (hereinafter referred to as the Insurance Agreement) that the Policyholder voluntarily concludes with Triglav Insurance, which organizes and implements voluntary health insurance (hereinafter: insurer).

These general terms and conditions regulate the rights and mutual obligations of the parties in the procedure of offering and contracting voluntary health insurance, the duration of insurance, general provisions on insurance premium, as well as the conditions under which certain rights are exercised, the scope of insurance coverage and other issues of importance for voluntary health insurance.

DEFINITIONS

Article 2.

The meaning of certain expressions in the General Terms:

Insurer: the insurance provider (hereinafter: Insurer) Triglav osiguranje a.d.o. Beograd;

Voluntary Health Insurance Policyholder (hereinafter referred to as the Policyholder): a legal or physical entity, as well as other legal form that, in the name of and for the account of the insured, that is, on their behalf and for the account of the insured, concludes the Agreement on Voluntary Health Insurance with the Insurer, and who undertakes to pay insurance premium from its own funds or from the funds of the Insured.

Offering Party: a person who sends a written offer to the Insurer for the conclusion of the contract on voluntary health insurance

Insured: a natural entity who concludes the Agreement on Voluntary Health Insurance or, on whose behalf, and with the consent of whom, the Agreement on Voluntary Health Insurance is concluded with the Insurer, and who uses the rights set forth in the Agreement on Voluntary Health Insurance, as well as a family member of the Insured;

Proposal: a written proposal that the Offering Party submits to the Insurer in order to conclude the Agreement on Voluntary Health Insurance;

Insurance Policy: a document on concluded Agreement on Voluntary Health Insurance with the Insurer;

Insurance Premium: the amount of money paid by the insured person or the policy holder to the Insurer on the basis of the concluded contract on voluntary health insurance

Collective insurance: voluntary health insurance contracted by the policyholder with the insurer, which he chooses in accordance with the law, on which the policy holder and the Insurer may conclude a contract on voluntary health insurance

Healthcare Services: services provided in healthcare institutions and other forms of healthcare services (hereinafter referred to as the Private Practice), in accordance with the law that regulates healthcare protection, for the purpose of conducting healthcare protection, i.e. for the purpose of implementation of measures for protection and improvement of people's health, prevention, combat and early detectionof diseases, injuries and other health impairments, for treatment and rehabilitation, including healthcare services from traditional medicine, which are safe, of good quality and efficient;

Healthcare Institution: a legal entity conducting a healthcare activity, which has obtained a license from the Ministry in charge of healthcare affairs (hereinafter referred to as: The Ministry) to conduct healthcare activities in accordance with the law that regulates healthcare protection and in accordance with related bylaws and regulations;

Private Practice: another form of healthcare service in which certain activities of the healthcare are conducted and which has obtained a license from the Ministry to conduct certain healthcare activities in accordance with the law that regulates healthcare protection and in accordance with related bylaws and regulations;

Other healthcare providers: other legal or natural entities that conduct certain healthcare activities, i.e. provide medical-technical aids, and which have obtained a license from the competent authority to conduct such activities, in accordance with law;

Medicine: a product which has been approved to be put on the market within the Republic of Serbia, as well as a product that has not been approved to be put on the market within the Republic of Serbia and which is imported on the basis of the approval of the Agency for Medicines and Medical Devices of Serbia, in accordance with the law that regulates the area of medicines;

Medical-Technical Aids: medical devices used to functionally and aesthetically replace missing parts of a body, or used to provide support, prevent deformities and correct the existing deformities, and to facilitate the performance of basic life functions;

Implant: medical aid which is surgically implanted into a human body;

Reimbursement: Fees incurred by the Insurer to the insured in case of loss of income or salaries or other earnings due to temporary work-related hindrance, transportation costs related to the use of health care, and other types of financial benefits related to the exercise of rights from voluntary health insurance

Insured sum: The monetary amount of compensation representing the maximum liability of the Insurer according to the concluded insurance contract

Secured event: The event which initiates an obligation for the Insurer to pay insurance compensation.

Waiting time: The period at the beginning of the term of insurance in which the contractor pays the insurance premium, and the Insurer has no obligation if the insured event occurs

A document on voluntary health insurance: The document which is issued by the Insurer to the insured, on basis of which the insured proves the status of the insured person under the voluntary health insurance and exercises rights from voluntary health insurance.

GENERAL PROVISIONS

Article 3.

By the Insurance Agreement, the Insurance Policyholder undertakes to pay the premium to the Insurer, and the Insurer undertakes, should the insured event occur, to compensate for the treatment costs or pay out pecuniary compensation in accordance with these General Terms and Conditions, Special Terms and Conditions and the Agreement on Voluntary Health Insurance.

All the notices and reports that the Parties are required to provide must be confirmed in writing, if made orally, over the phone or otherwise.

The date of receipt of the notice, i.e. the report referred to in paragraph 2) of this Article, shall be deemed the day when the Insurer receives the notice or the report, or the date indicated in the Insurer's registry.

Agreements that are related to the contents of the Voluntary Health Insurance contract shall be valid only if concluded in writing.

TYPES OF INSURANCE

Article 4.

The types of voluntary health insurance that the Insurer provides:

1. Parallel health insurance is the insurance that covers the costs of healthcare protection incurred when the Insured uses the healthcare protection that is covered under the mandatory healthcare insurance in the manner and in accordance with the procedure other than the manner and procedure of exercising the rights under the mandatory healthcare insurance, in accordance with the general and special conditions of the Insurer;
2. Supplemental health insurance is the insurance that covers the costs of healthcare services, medicines, medical-technical aids and implants, i.e. pecuniary compensation, not covered by rights under the mandatory health insurance, i.e. insurance for a greater contents, scope and standard of rights, as well as the amount of pecuniary compensation covered by the mandatory health insurance, in accordance with the general and special conditions of the Insurer;
3. Private health insurance is the insurance of persons who are not covered by the mandatory health insurance or who are not included into the mandatory health insurance, to cover the costs of the type, contents, scope and standard of the rights that are contracted with the Insurer;
4. A combination of parallel and additional health insurance.

BECOMING AN INSURED

Article 5.

The status of an Insured under the parallel, i.e. supplemental voluntary health insurance may be gained by a person who has obtained the status of an insured under the mandatory health insurance in the Republic of Serbia, and who expresses a clear intention to conclude the Agreement on parallel or supplemental voluntary health insurance with the Insurer, in accordance with the general and special conditions of the Insurer;

The status of the Insured in private voluntary health insurance may be gained by a person who is not insured by the mandatory health insurance, and who expresses a clear intention to conclude the Agreement on private voluntary health insurance with the Insurer, in accordance with the general and special conditions of the Insurer;

The members of the family of the Insured can also become insured, in accordance with the Special conditions of the insurer.

CONCLUDING THE AGREEMENT

Article 6.

The Proposal makes an integral part of the Insurance Agreement.

The Insurance Agreement is concluded on the basis of a written proposal, on a form of the Insurer, which is submitted by the Offering Party.

In case that the Agreement on Collective Insurance is to be concluded, the Policyholder may submit a unified proposal which contains data on each individual person who wants to be insured by the Insurer.

Multiple insurance by one policyholder under one policy can be contracted only on condition that all insured persons have the same coverage level.

The proposal must state accurately, truthfully and completely all the information necessary for the conclusion of the insurance contract, as well as all the facts that are of significance for the risk assessment.

An integral part of the insurance offer, when concluding individual insurance, is a questionnaire on the health condition of the insured, provided on the printed form of the Insurer.

Upon receipt of a proposal for the conclusion of a contract, the Insurer may request additional information on the health condition of the potential insured, i.e. may request from the potential insured to submit the documentation (medical or laboratory reports, findings, etc.) or, if necessary, to perform a medical examination.

The insurer performs a risk assessment for each insured person, that is, he / she has the right to accept the person for whom he / she determines that he / she presents an increased risk, but with an increased premium.

The provisions that specify the increased risks are contained in the Special Terms and Conditions of the Insurer.

A proposal to the Insurer to conclude an insurance contract shall bind the offering party to a period of 8 days from the date of receiving the proposal, if a shorter period is not specified, and for a period of 30 days, if a medical examination is required.

It is considered that the Insurer has received a written proposal on the day when it is officially registered in any organizational part of the Insurer.

Upon receipt of the proposal, the Insurer requests additional information in accordance with paragraph 6 of this Article, or requests a medical examination for the potential insured, the proposal is considered received when the Insurer receives the requested additional information or the requested medical reports after the medical examination.

If the offering party does not submit the requested information within eight days after the written request of the Insurer, counting from the date of receipt of the written request of the Insurer to submit the requested information, the offering party will be deemed to have renounced their offer or the conclusion of the insurance contract.

If the offering party does not submit the results of the performed medical examination within a period of 30 days upon the written request of the Insurer, counting from the date of receipt of the written request of the Insurer for the submission of the requested data, the offering party will be deemed to have renounced their offer or the conclusion of the insurance contract.

The obtained health data on the potential insured cannot be a reason for refusing admission to insurance, but the insurer uses it for risk assessment in order to calculate the insurance premium.

By its signature on the proposal, i.e. the policy, the Insured, or the Policyholder, confirms the acceptance of the General and Special Conditions.

TERM OF THE INSURANCE AGREEMENT

Article 7.

According to the General Conditions, the insurance contract is concluded for a period that cannot be shorter than 12 months counting from the date of conclusion of the contract, unless the insured person terminates the status in accordance with the regulations from the mandatory health insurance.

Article 8.

The insurer's obligation shall begin on the twenty-fourth hour of the day which is in the policy stated as the beginning of insurance, but not before the date when the premium is paid, or the first instalment of the premium is paid, unless otherwise specified in the policy or in special terms.

It is also considered that the first contracted premium is paid if the policy holder or the insured has given a written statement on the basis of which the premium is collected through the suspension of his salary.

If the first contractual insurance premium is not paid until the date indicated in the policy as the commencement date of the insurance period, the Insurer's obligation shall begin on the twenty-fourth of the day when the first agreed premium is paid in entirety.

If the waiting period is agreed, the Insurer's obligation shall begin on the twenty-fourth hour of the day which is indicated as the expiration date of the waiting period, provided that the insurance premium has been paid.

Article 9.

The insurance contract shall terminate for each individual insurer within 24.00 hours period regardless of the agreed duration in the case of:

- death of insured person – on the day of death;
- loss of the status of the insured person in compulsory health insurance - the day of losing the status;
- in the case of private health insurance - obtaining the status of a mandatory insured person, on the day of receiving the status
- failing to perform the payment of premium;
- in other cases, in accordance with the regulations, General and special terms and conditions of the Insurer.

WAITING PERIOD (WITHDRAWAL PERIOD)

Article 10.

An insurance contract may define a withdrawal period or the period of time in which the Insurer has no obligation to pay compensation if the insured event occurs.

The withdrawal period shall be calculated from the beginning of the insurance specified in the policy, provided that by that date the first agreed premium has been paid.

If the due premium is not paid until the beginning of the insurance, the withdrawal period is calculated from the expiration of the 24: 00 hour of the day when the first agreed premium is paid.

Waiting periods do not apply in case of a renewal of an insurance contract.

INSURANCE PREMIUM

Article 11.

The amount of premium is determined by the Insurer in accordance with the premium tariff (hereinafter: tariff) and regulations governing the area of voluntary health insurance.

The Insurer may not increase the premium during the term of the Agreement on voluntary health insurance.

Exceptionally from paragraph 2) of this Article, in case of Agreements concluded for a period of several years, the premium may be changed after expiry of a 12-month period from the date of concluding the Insurance Agreement, i.e. every 12 months until expiry of the term of the Insurance Agreement concluded.

The policy holder is required to pay to the insurer a premium on the maturity, within the deadlines determined by the contract or insurance policy.

If it is agreed that the annual premium is paid in semi-annual, quarterly or monthly instalments, the Insurer shall be entitled to an insurance premium for the entire year of the insurance.

Notwithstanding paragraph 5 of this Article, in the event of termination of insurance due to the death of the insured, the Insurer shall be entitled to the premium until the day the insurance is effective.

The insurer has the right to charge a legal default interest to the policy holder for each day of exceeding the deadline in which he is required to pay the due insurance premium.

The first agreed insurance premium, i.e. the first instalment of the premium, is due until the start of the insurance contract.

Each subsequent instalment of insurance premium is due on the last day of the current time period (semi-annual, quarterly, monthly) and is valid for the following period of time.

Payment of outstanding premium instalments always refers to the first unpaid premium and the Insurer has the right to charge for the unpaid premiums and interest on instalments on any reimbursement under the contract.

The insurance premium shall be recognized as paid on the day when the payment is recorded on the Insurer's account.

The insurer is required to accept the payment of the insurance premium made by any person having a legal interest in paying the insurance premium.

A DOCUMENT ON VOLUNTARY HEALTH INSURANCE

Article 12.

On the day of issuing the insurance policy, and at the latest within 60 days, the insurer is required to issue to each insured a document on the basis of which the rights from voluntary health insurance (hereinafter referred to as: document) are exercised.

By this document, the Insured proves the status of the Insured and exercises rights from voluntary health insurance.

The document is valid for the period of insurance.

The document is valid when accompanied by an identity card or other identification document of the insured.

The insured is required to report the loss of the document without delay, in writing, to the department of the Insurer performing the activities of voluntary health insurance. In this case, the Insurer is required to issue a duplicate of the document at the additional costs.

RISKS COVERED BY INSURANCE

Article 13.

The insured event is an event where a medically justified treatment (health services, medicines, medical-technical aids, implants, etc.) is carried out for the insured person due to health disorders (illness or injury) and which is the subject of the insurance contract and the expenses of which have to be paid to the health insurance institutions, private practice, other health care provider or insured person.

If an insured event occurs within the scope of these Terms, the insurer is required to reimburse the insured for the standard and usual expenses up to the agreed amount of coverage, which arise during the term of the insurance contract, in connection with a medically justified treatment performed for the insured.

Notwithstanding paragraph 2 of this Article, if the insured event occurred prior to the beginning of the insurance coverage, and the treatment for that insured event also takes place after the beginning of the insurance coverage, the Insurer is not required to bear the costs incurred for such treatment.

In any case, the insured event ends with expiry of the insurance contract, in accordance with the General Conditions.

Article 14.

The amount of the insurance coverage, as well as the obligations of the Insurer under the insurance contract are determined by the special conditions of the Insurer.

The insured sum indicated in the insurance policy represents the maximum liability of the Insurer, according to the concluded contract.

The insurance coverage is valid 24 hours a day during the contracted term of the insurance, at the territory of the Republic of Serbia, unless otherwise stipulated by special conditions.

PARTICIPATION OF THE INSURED IN TREATMENT COSTS

Article 15.

The contracting party and the Insurer may define by a contract the participation of the insured in any claim, i.e. the cost of health services, in the appropriate amount or percentage.

In this case, the insured participates in the corresponding percentage or amount in such a way that the amount of the contracted participation of the insured is deducted from the total amount of the Insurer's due liabilities.

If the value of the occurred damage is less than the contracted, the Insurer has no obligations regarding the payment of the compensation up to the amount of the contracted share.

The contracted participation of the insured in the damage is applied for each insured event that occurs during the term of the insurance.

OBLIGATIONS OF THE INSURER

Article 16.

The Insurer is bound to enable the Insured to exercise his/her rights provided under the Agreement on voluntary health insurance, as well as the rights defined in these General Terms and Conditions and Special Terms and Conditions.

In line with the Insurance Agreement, i.e. Policy and Special Terms and Conditions, the Insurer is required to compensate a healthcare service provider or the Insured for treatment costs or a part thereof incurred due to exercising the rights under the contracted voluntary health insurance, as well as the agreed amount of pecuniary compensation, within 14 days as of the date when received complete documentation based on which the indisputable existence and scope of liability can be established.

The Sum Insured specified in the Policy represents the top limit of the Insurer's obligation under the Insurance Agreement.

The Insurer is entitled to request from the Insured, Policyholder or any other legal or physical entity to provide additional explanations or additional documentation in order to establish important circumstances relevant for the reported Insured Event.

The Insurer is entitled to refer the Insured to a control medical examination or additional medical evaluation, by which necessary circumstances relevant for the reported insured event would be established. The costs of such evaluations are borne by the Insurer.

EXCLUSIONS OF THE INSURER'S OBLIGATION

Article 17.

The insurer is not to pay the insurance fee in the following cases:

if the insured gave incorrect and false information, or concealed important circumstances of significance for the conclusion of the insurance contract;

if the contracting party, or the insured person does not pay the premium for the insurance until the agreed deadline, nor it is not done on his behalf by another person;

in the event of abuse of the insurance policy or document,

If the volume of contracted health services and the amount of costs is exceeded,

If the claim is based on false data and false documentation.

If the subject of the claim is the cost of organizing and implementing the preventive programs of vaccination, immunoprophylaxis and chemoprophylaxis

for reimbursement of health care costs and payment of benefits covered by compulsory health insurance, except for private health insurance.

OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED

Article 18.

In addition to the obligations stipulated by the regulations governing the field of voluntary health insurance and General and special conditions of the Insurer:

1. when realizing the rights from voluntary health insurance, at a medical institution, private practice or other health care provider, the insured person is required to provide the document;
2. the insurance policyholder, or the insured, is required to inform the Insurer within the shortest reasonable time about any changes in the data about the insured persons (such as changing the address, occupation or marital status, termination of employment, etc.) or any other important changes such as the change in the number of insured persons, which influence the correction of the insurance risk assessment.

TERMINATION OF INSURANCE AGREEMENT

Article 19.

If the contracting party fails to pay the premium by the due date nor does any other interested party does that, the insurance contract expires after the expiration of the thirtieth day from the day when the contracting party received the registered letter from the insurer with a notice on the maturity of the premium, but that deadline cannot expire before the expiration of 30 days from the date of maturity of the premium.

In any case, the insurance contract ceases according to law if the premium is not paid within one year from the due date.

In case the Policyholder or the Insured made a false claim or withheld a circumstance that was of such nature that the Insurer would not have concluded the Agreement under the same terms and conditions had it known about the actual state of affairs, the Insurer may request the annulment of the Agreement.

CANCELLATION OF THE INSURANCE AGREEMENT

Article 20.

Each contracting party may cancel an insurance contract with an indefinite duration, unless the contract has terminated on some other basis.

Cancellation is made in writing, no later than three months before the end of the current year of insurance.

If the insurance is concluded for a term longer than five years, each party may, after the expiration of the agreed deadline, with a notice period of six months, declare in writing to the other party the wish to terminate the contract.

COMPLAINTS OF THE INSURED

Article 21.

An insured who is dissatisfied with the decision of the Insurer regarding a claim can submit a complaint to the Insurer's Complaints Committee within eight (8) days from the date of receiving the decision.

The Complaints Committee is requested to make a written decision on the complaint within 30 (thirty) days from the day of receipt of the complaint referred to in paragraph 1 of this Article and to notify the insured thereof.

DATA ON THE INSURED

Article 22.

The Insured authorizes the Insurer to collect, verify, process, store, transfer and use personal data necessary to conclude the Insurance Agreement in accordance with the law governing personal data protection.

The Insurer undertakes to keep the data referred to in paragraph 1) of this Article as a business secret, in accordance with law.

During the conclusion of the contract the insurer will not ask for genetic data, that is, the results of genetic tests for certain hereditary diseases of the person who shows a clear intention to conclude the contract, as well as for his relatives, regardless of the type and level of kinship.

THE RIGHT TO RECOURSE

Article 23.

The rights of the Policyholder or the Insured towards a third party are transferred to the Insurer, in the amount of the liability paid out by the Insurer, without the need to obtain any special consent of the Insured person.

In order to exercise the right to recourse as stipulated in paragraph 1) of this Article, the Insured is obliged to provide to the Insurer all the evidence that the Insurer may request from it, and that is related to the insurance claim.

The costs of obtaining such evidence are borne by the Insurer.

TRANSITIONAL AND FINAL PROVISIONS

Article24.

These General Terms and Conditions may be amended following the procedure and manner in which they are adopted.

Regarding existing insurance agreements, the General Terms and Conditions based on which such agreements were concluded shall apply until expiry of the insurance year, unless the terms and conditions are changed as a result of changes in legal regulations, which is beyond control of the Insurer.

Should the Insurer amend the General Terms and Conditions of Insurance, it is obliged to make a notification thereof to the Policyholder, i.e. the Insured, with whom it has concluded Insurance Agreement for a perennial term. in writing, as well as in another convenient way (daily press, radio, television, the Insurer's web site, etc.) at least 30 days before the end of the current year of insurance.

The contracting party has the right to cancel the insurance contract within 30 days from the day of receipt of the notice referred to in paragraph 3 of this Article. In that case, the contract referred to in paragraph 2 of this Article shall terminate at the expiration of the current year of insurance.

If the contracting party does not cancel the insurance contract within the term referred to in paragraph 4 of this Article, the insurance contract shall be renewed in accordance with the changes made in the General terms and conditions of insurance. The contracting party may, until the date of application of the new General Conditions, notify the Insurer on the cancellation of the insurance contract, in which case the insurance contract shall terminate on the day of the application of the new General Conditions. Otherwise, the new General Conditions will apply to the new agreement.

Article 25.

Claims arising from the contract expire under the provisions of the Law on Obligations.

Article 26.

The Contracting Parties shall settle all disputed issues by mutual agreement, and if they fail to do so, they shall contract the jurisdiction of the competent court in the seat of the Insurer.

Article 27.

The provisions of the Law on Obligations and Regulations governing voluntary health insurance are directly applied to all relations of the contracting parties that are not defined by these conditions.

Article 28.

These General Terms and Conditions shall enter into force on the eighth day after the date of their publication on the notice board of the Insurer, and shall be applied upon the approval of the Ministry of Health.