

Insurance rules

2010

Confirmed by the council of “INGO ARMENIA” ICJSC (protocol #23 on 25.01.2010). Effective since February 1, 2010.

Traveler’s assistance insurance

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Rules of traveler’s assistance insurance, hereinafter Rules, are concluded in accordance to the legislation of the RA and other normative acts, and constitute an integral part of traveler’s insurance agreement. Upon consent of the Parties, insurance agreement may include other norms.

1. Subject of insurance

- 1.1 “INGO ARMENIA” ICJSC is the Insurer and concludes traveler’s assistance insurance agreement.
- 1.2 According to insurance agreement, the Insured may be a legal entity and/or a capable individual.
- 1.3 The Insured is entitled to conclude agreements for benefit of third persons (hereinafter Insured person). If the agreement is concluded for benefit of the Insured, all obligations of the Insured person are applied to him. According to Rules of present agreement, the Insured person may only be an individual.

2. Object of insurance

- 2.1 The object of insurance is valuable interest of the Insured person, concerning medical expenses in the period of being in a country or countries, mentioned in the insurance Policy for necessity to receive medical help, organize repatriation, other services (including medical-transportation expenses, which have occurred in the period of effectiveness of the insurance Policy).

3. Insurance accidents

- 3.1 According to present Rules, insurance accident is an event, defined in the insurance agreement, as a result of which the obligation of the Insurer to pay insurance compensation is occurred.
- 3.2 The following are considered to be an insurance accident: sudden illness, accident, as well as death of the Insured person, on condition that the above-mentioned has occurred during the trip to

the country, noted in the insurance agreement and during the period of effectiveness of the insurance Policy.

3.3 Sudden illness is considered to be an illness that has occurred during the effective period of insurance Policy and demands emergency medical interference.

3.4 Accident is considered to be a confluence external, short-term (up to a few hours), unintended and unforeseen circumstances and conditions, as a result of which harm to the health, or death of the Insured person approaches, not subject to the wish of the insured person.

3.5 Events, mentioned in points 3.2-3.4 of the Rules are not considered as insurance accidents, if they are occurred as a result of:

3.5.1 being of the insured person under influence of alcohol, narcotic, toxic or other intoxication, the fact of which is confirmed in accordance with the legislation of the country, where the insured person was at the moment of insurance accident occurrence.

3.5.2 suicide of the insured person (attempt of suicide),

3.5.3 influence of nuclear explosion, radiation, radioactive or other contamination,

3.5.4 natural disasters and their consequences, epidemics, quarantine, meteorological conditions,

3.5.5 designed actions of the insured person and/or interested third persons, directed on occurrence of insurance accident,

3.5.6 commitment of unlawful actions, that are in direct cause-effect relation with occurrence of insurance accident,

3.5.7 flight of the Insured person by aircraft, its driving, except cases of flights as a passenger of civil aircraft, controlled by professional pilot,

3.5.8 flight of the Insured person by non-motor aircraft, motor glider, superlight flying vehicles,

3.5.9 military actions and their consequences, civil commotion, strikes, revolt, mass riots, acts of terrorism and their consequences,

3.5.10 service of the Insured person in any armed forces and groups,

3.5.11 professional sport activity of the Insured person,

3.5.12 engagement of the Insured person in amateur and organizational sports, including: alpinism, rock climbing, rafting, riding, diving, mountain skiing, skiing on snowboard as well as jump and flying by parachute, unless otherwise agreed in the agreement.

3.5.13 engagement of the Insured person in activity, that is connected to be an increased danger, (including miners, constructors, electricians),

3.5.14 if the aim of insurance of the Insured person is to receive of medical help. Besides, the Insurer does not compensate expenses or health recovery, that are the aim of travel of the Insured person, as

well as expenses concerning health worsening or death of the Insured person, in connection with such medical help.

3.6 Events, mentioned in points 3.2-3.4 of the Rules are not considered to be insurance accidents, if they are occurred as a result of:

3.6.1 chronic diseases that are known at the moment of concluding insurance agreement, as well as diseases that existed before the start of effective period of the Insurance policy, regardless their having been treated or not.

3.6.2 oncological diseases,

3.6.3 mental diseases, convulsive state, neurosis (panic attacks, depression, hysteric syndromes and etc.),

3.6.4 existence of HIV/AIDS and any forms of hepatitis,

3.6.5 lead of pregnancy and/or its break without any response to the term of pregnancy.

3.7 Upon additional agreement of the Parties, specified in the insurance agreement, events described in points 3.5.7-3.5.13 of the Rules may be considered as insurance accident. The Insurer may also compensate expenses described in points 4.6.3, 5.1.1, 5.1.7, 5.1.22. Besides, the Insurer may apply increasing rates.

4. Expenses covered by the Insurer

4.1 In case of insurance accident occurrence, the Insured person before applying for or visiting medical facilities, is obliged to call the Service Centre and inform of the details if it is defined by the insurance agreement (Policy) and if the Insured person together with the insurance Policy was presented appropriate individual card. In this case the Service Centre organizes the service providing, foreseen by the insurance agreement, and the Insurer pays for these services.

Under Service Centre in present Rules is understood specialized organization, the contacts of which are mentioned in the insurance agreement (Policy) of the Insured person, which by the order of the Insurer secures a 24 hour organization of services, defined by the insurance agreement.

According to present Rules and in accordance with the insurance agreement, the Insurer compensate following expenses to specialized organizations that organize and perform below-mentioned measures or directly to the Insured person in case of presenting documents that confirm providing of such services:

4.2. Medical expenses, i.e.:

4.2.1 expenses of being in medical centre and treatment at hospital (in a standard room), including expenses for medical services, for surgical operations, diagnostic researches, as well as for medicine, dressing materials and fixing materials (band, gypsum), written out by doctor.

4.2.2 expenses for ambulatory treatment, including expenses for medical services, diagnostic researches, medicine, dressing and fixing materials (band, gypsum), written out by doctor.

4.2.3 On the territory of Turkey for expenses, indicated in points 4.1.1. and 4.1.2 a deductible of 200 USD in equivalent AMD is applied:

4.2.4 On the territory of the USA for expenses, indicated in points 4.1.1 and 4.1.2 maximal limit of daily costs is applied to the amount of 1500 USD in equivalent AMD.

4.3. Medical-transportation expenses, i.e.:

4.3.1 evacuation expenses (transportation by ambulance car) from the site of insurance accident occurrence to the nearest medical facility or to a doctor, as well as expenses for transfer to other medical facility, predefined by the treating doctor and confirmed by the conclusion of the doctor of the Insurer/Medical Centre.

4.3.2 expenses for urgent medical repatriation by adequate transportation mean, including expenses on the accompanying person (if such accompany is predefined by the doctor) from the abroad to the place of inhabitancy of the Insured person, on condition of absence of possibility to receive demanded medical help in the sojourn country. **Urgent medical repatriation** is executed exceptionally in cases, when its necessity is confirmed by the conclusion of the doctor of the Insured on the basis of documents from the local doctor and on condition of absence of medical contraindication. Expenses for **urgent medical repatriation** are covered within the limits of the sum insured, defined in the insurance Policy.

4.3.3 expenses for **medical repatriation** of the Insured person from the abroad to the place of inhabitancy in cases, when the expenses for staying in hospital may exceed the sum insured defined in insurance Policy. **Medical repatriation** is executed only in case of absence of medical contraindications. Expenses for **medical repatriation** are covered within the limit of the sum insured, define in insurance Policy.

4.4 Posthumous repatriation expenses, i.e.:

Posthumous repatriation expenses for transportation the body of the Insured person to his/her place of inhabitancy, sanctioned by the Service Centre, if his/her death approached as a result of insurance accident. **Posthumous repatriation expenses** are covered within the limits of the sum insured, defined in the insurance Policy. Besides, the Insurer does not compensate expenses of ritual services on the territory of the inhabitancy of the Insured person.

4.5. Expenses of the Service Centre for organization of help, foreseen by present Rules, i.e.:

The methods of transportation of the Insured (points 4.3.1-4.3.3 and 4.6.1-4.6.3) person are defined by the Insurer/Service Centre taking into account medical dispensation. Besides, the Insurer is not liable in case of not preserving to the transportation schedule by the carrier.

4.6. Transportation costs, i.e.:

4.6.1 expenses of the Insured person to one-way reach the place of inhabitancy of the Insured person by economy class, expenses for reaching TN (airport, railway station) in the sojourn country which

has direct international communication with the settlement of the place of inhabitancy of the Insured person. Mentioned expenses are compensated in cases, if the departure of the Insured person has not been made on time, i.t. on the day stipulated in travel document which the Insured person holds, as a result of insurance accident occurrence, which brought to necessity of the Insured person to be under medical treatment in hospital. The Insured person is obliged to do his best in order to return (hand in) unused travel documents and compensate their value to the Insurer. In case of not observance of these conditions, the Insurer is entitled to deduct appropriate value of the unused travel documents from the sum that is subject to be paid to the Insured person as insurance compensation.

4.6.2 expenses for one way travel of children, that were together with the Insured person while being abroad by economy class to the country of their inhabitancy in case, if the children have remained unattended as a result of insurance accident, occurred to the Insured person. If necessary, the Insurer organizes and pays for accompany of the children.

4.6.3 expenses for travel forth and back by economy class from the country of inhabitancy and back of one relative of the Insured person, if the term of hospitalization of the Insured person, who was traveling lonely, has exceeded 30 (thirty) days. (unless different term stipulated in the insurance agreement). The Insurer does not cover expenses of staying of the relative abroad.

4.7. Assistance in organizing legal consultation:

4.7.1 If necessary, the Service Centre of the Insurer implements assistance in receiving legal consultation by the Insured person, as well as while investigating crime and civil cases during the stay of the Insured person in the territory of the country, stipulated in the insurance Policy, during the validity period of the insurance Policy.

4.7.2 All expenses for providing legal help (consultations) are at the Insured person's cost.

4.7.3 The person who provided legal help to the Insured person is directly liable for its quality.

5. Expenses, not covered by the Insurer

5.1 The Insurer does not cover the following expenses:

5.1.1 expenses connected with treatment of chronic diseases, known or existing at the moment of concluding insurance agreement, regardless their having been treated or not,

5.1.2 expense in connection with worsening of health condition of the Insured person, concerning treatment that the Insured person had passed before the start of the insurance agreement as well as in case if the travel was contradicted for the Insured person because of the condition of his/her health,

5.1.3 expenses for relief and treatment of convulsive state, nervous and mental diseases,

5.1.4 expenses for diagnostic manipulations (including consultations and laboratory researches) without after treatment,

5.1.5 expenses for angiography, as well as expenses in connection with surgical operations on heart and vessels, including angioplasty and shunting even in case of presence of medical evidences for their performance,

5.1.6 expenses for treatment of oncological diseases,

5.1.7 expenses for treatment of solar burn and other sharp change of coetaneous covering occurred by the influence of ultraviolet radiation,

5.1.8 expenses for receiving such medical services by the Insured person, that are not connected with the sudden disease or accident; for prophylactic measures and general medical inspection,

5.1.9 expenses for treatment of HIV/AIDS as well as their consequences,

5.1.10 expenses in connection with consultations and researches during pregnancy, researches and treatment of pregnancy complications, regardless the term of pregnancy, as well as postnatal control, except cases when medical help is necessary for saving the life.

5.1.11 expenses connected with induced abortion except cases, when the operation is made in order to save the life of the Insured person.

5.1.12 expenses for treatment of sexually transmitted diseases, as well as diseases that are their consequences.

5.1.13 expenses connected with plastic, restorative surgery, transpathology (transplant operation) and any kind of prosthetics, including dental and optic prosthetics.

5.1.14 expenses for dental help, except expenses for inspection, urgent treatment and medicine in case of acute inflammation of teeth and tooth tissues, as well as in case of tooth injury as a result of accident.

5.1.15 expenses connected with providing services that are no necessary from the medical point of view or with treatment that is not assigned by the doctor.

5.1.16 expenses occurred as a result of voluntary rejection of the Insured person to perform the assignments of the doctor, received when applying to inform about insurance accident occurrence.

5.1.17 expenses for treatment by manual therapy, reflex therapy (acupuncture), chiropractor, massage, homeopathy, herbal and natural therapy and etc.

5.1.18 expenses for treatment or care of the Insured person performed by his relatives as well as expenses connected with securing the stay of the relatives of the Insured person, conditioned by his treatment and following return to the country of inhabitancy,

5.1.19 expenses connected with providing medical services by medical institution that does not have appropriate license, or by person who does not have right to implement medical activity,

5.1.20 expenses for rehabilitation, restorative treatment and physiotherapy,

5.1.21 expenses for passing course of treatment at health resorts, sanatoriums, boarding house, holiday house and other similar facilities,

5.1.22 expenses for execution of disinfection, vaccination, medical expertise, laboratory and diagnostic researches not connected with accident or sudden disease,

5.1.23 expenses connected with providing additional comfort, i.e.: “luxe” room, TV, telephone, conditioning, moisturizer, services of hairdresser, masseur, cosmetologist, translator and etc.,

5.1.24 expenses that occurred after the return of the Insured person to the country of inhabitancy as well as after the validity period of the Insurance Policy,

5.1.25 expenses that exceed the defined sum insured,

5.1.26 expenses for in-patient treatment, medical-transportation, transportation, posthumous repatriation, which are not authorized by the Service Centre.

5.2 If the insurance agreement foresees non conditional deductible (the sum that is paid by the Insured person to the doctor/medical facility and is not compensated by the Insurer), it is applied for pay of services for each insurance accident.

6. Sum insured, insurance premium

6.1 Sum insured is the sum of money that is defined by the insurance agreement, on the basis of which the amount of insurance premium and insurance compensation in case of insurance accident occurrence is defined. The sum insured is defined upon the consent of the Parties. The total sum of compensation for one or several insurance accidents that are occurred during the validity period of the insurance Policy may not exceed the amount of the sum insured, defined in the insurance Policy.

6.2 Insurance premium is the pay for insurance, which the Insured is obliged to pay to the Insurer (his authorized representative) in accordance with insurance agreement.

6.3 Insurance premium is defined by the Insurer in accordance with its rates. In case if the Insurer decides to accept for insurance persons that exercise increased danger activity, including activities, foreseen in points 3.5.7-3.5.13 of present Rules, as well as persons up to 3 and more than 65 years old, the amount of insurance premium is defined in accordance with the increasing rates of the Insurer.

6.4 Insurance premium is paid by the Insured by one-off payment for the whole period of insurance unless otherwise foreseen by the insurance agreement.

6.5 The pay of insurance premium may be performed in noncash form or in cash. The insurance premium is considered paid: in noncash form – since the date of receipt of the insurance premium on the account of the Insurer; in cash form – since the moment of payment of the insurance premium in the cash desk of the Insurer (according to the receipt ticket of the Insurer or its authorized representative).

6.6 Insurance premium may be defined both in AMD or foreign currency, according to current legislation of the RA and upon consent of the Parties. Insurance premium defined in foreign currency is paid in AMD according to the exchange rate of the CBA of the RA on the day of payment, unless other exchange rate provided upon the consent of the Parties.

6.7 Insurance premium is subject to payment before receipt of the insurance Policy by the Insured, but not later than 5 working days from the date of submission of application for insurance agreement conclusion.

6.8 In case of nonpayment of the insurance premium on conditions defined by the agreement, the insurance agreement is considered not effective and bears no consequences for the Parties (unless otherwise foreseen in the insurance agreement).

6.9 The amount of the insurance premium is defined and mentioned in the insurance agreement (Policy) or in the insurance premium invoice which constitute an integral part of the insurance agreement.

7. Insurance agreement effectiveness

7.1 Insurance agreement is concluded for the term of period of travel of the Insured person, but not more than one year, unless otherwise foreseen by the insurance agreement.

7.2 If the insurance agreement provides multiple travel abroad of the Insured person during the period of insurance, the Insurer is liable only for the defined quantity of days, defined in the insurance agreement. For each travel to the territory of insurance cover, the quantity of insurance days is automatically deducted by the days of travel in the country where the insurance agreement is effective. The liability of the Insurer is terminated upon the expiry of the limit of defined days of insurance, stipulated in the insurance Policy.

7.3 If one year insurance agreement provides multiple travels of the Insured person, the insurance cover is expanded for the first 90 days of each travel, unless otherwise stipulated in the insurance agreement.

7.4 Insurance agreement is not valid:

- For foreign citizens in the country where the Insured person is registered or whose citizen he is.
- For the citizens of RA, in the range of 30 km from the place of inhabitancy of the Insured person.

7.5 Insurance agreement comes into effect starting from the 00.00 hours of the next day of the insurance agreement conclusion but not before the payment of insurance premium for the whole period of insurance by the Insured and only in case of passing the state border of the country of departure (notice of border services in the passport) of the Insured person, unless otherwise provided by the insurance agreement. The date of insurance agreement conclusion is considered the

date of Policy issuance or the date of sign of the agreement, if the insurance agreement is formed by one document.

7.6 If to the moment of expiry of the insurance agreement period the return of the Insured person is not possible in connection with hospitalization, as a result of insurance accident, which is confirmed by appropriate medical conclusion, the Insurer performs his obligations under section 4 of present Rules, concerning that insurance accident during 4 (four) weeks starting from the day, mentioned in the insurance Policy as the day of expiry of the insurance agreement.

8. Conclusion of the insurance agreement

8.1 Insurance agreement is concluded before the start of the travel. For conclusion of insurance agreement the Insured presents to the Insurer (his authorized representative) oral or written application of his intention to conclude insurance agreement and passes following data:

8.1.1 name, family name, patronymic name in Armenian, Russian or in English, date of birth of the Insured person, telephone, address;

8.1.2 title, legal address, telephone, banking details, if the Insured is legal entity;

8.1.3 name, family name, patronymic name of the Insured person (persons) in Armenian, Russian or English, date of birth, passport data, telephone of the Insured person,

8.1.4 planned start and end of the travel;

8.1.5 countries, on the territory of which the insurance agreement is effective;

8.1.6 aim of travel,

8.1.7 profession and type of supposed activity, if the Insured person travels for business aims,

8.1.8 type of sport or type of sport competition, where the Insured person is supposed to take part,

8.1.9 sum insured,

8.2 When concluding insurance agreement, the Insured is obliged to inform the Insurer of any circumstances known by him, that have essential concern for calculating insurance risk.

8.3 The Insured is obliged to inform the Insurer of any changes of the risk insured that take place during the validity period of the insurance agreement.

8.4 Insurance agreement is concluded without medical examination of the Insured person. The Insured person has to fill in questionnaire upon demand of the Insurer.

8.5 The fact of insurance agreement conclusion is confirmed by giving the Insured an insurance Policy and attached insurance Rules.

8.6 When concluding insurance agreement, the Insured person releases the doctors from the obligation of confidentiality towards the Insurer.

8.7 The Insurer is entitled to reject conclusion of insurance agreement without any explanation.

9. Relations between the Parties in case of insurance accident occurrence

9.1. If the insurance agreement provides obligatory appeal to the Service Centre, the Insured person is obliged:

9.1.1 inform the Service Centre by the telephone numbers indicated in the insurance Policy or on the individual card about the accident in advance, before referring or visiting medical facility in advance, and inform the following data:

- Name, family name of the Insured person;
- Insurance Policy number;
- Type of necessary help;
- Location and telephone number for feedback;

9.1.2 receive medical help in strict accordance with the instructions of the Service Centre operator;

9.1.3 present the original insurance Policy to the medical personnel;

9.1.4 pay the deductible, if provided by the insurance Policy;

9.1.5 coordinate actions and follow instructions of the operator;

9.1.6 if the validity period of the insurance agreement exceeds the quantity of the insured days, the Insured person is obliged to documentally prove to the Insurer, that the insurance period at the moment of applying for medical or medical-transportation help has not expired, by presenting the passport with appropriate notes of border control on passing the state border;

9.1.7 observe the instructions of the doctor and the routine, defined by the medical facility;

9.1.8 in case of impossibility to contact the Service Centre at the moment of insurance accident occurrence, do it at the very first opportunity and present the insurance Policy, without paying for the services, provided by third persons without the official confirmation of the Service Centre operator;

9.1.9 substantiate to the Insurer in written form on the reasons of not execution of the demands indicated in points 9.1.1. of present Rules and present appropriate confirmatory documents.

9.2 After receiving information, the Insurer or the Service Centre organizes rendering of necessary medical medical-transportation help to the Insured person, in accordance with the insurance agreement on free basis, and the Insurer will pay to the Service Centre for the rendered services to the Insured person in accordance with section 4 of present Rules. Expenses for the initial call to the Service Centre are compensated to the Insured person in case of presenting the originals of the confirmatory documents.

9.3. In case of infringement of points 9.1-9.2 of present Rules, expenses born directly by the Insured person are not subject to compensation.

9.4 If the insurance agreement (Policy) does not provide obligatory appeal to the Service Centre, the Insured person is entitled to get medical and other services by one of the following methods:

9.4.1 in strict accordance with the procedure, indicated in point 9.1 of present Rules.

9.4.2 appeal himself to the nearest medical facility, present insurance Policy, pay for the rendered services. In this case the Insurer does not perform any measures for revealing conformation and receiving documents indicated in point 9.5 of present Rules.

9.5 In case of self-reliant payment of medical services, the Insured person after returning from the travel presents following original confirmatory documents to the Insurer:

- Written application on the accident, including the reasons for not applying to the Service Centre;
- Insurance Policy;
- Medical documents that contain data on the diagnosis, the date and the condition of the Insured person when applying for medical help, on performed medical manipulations and the period of treatment;
- Prescriptions in connection with particular disease written out by the doctor with the stamp of the pharmacy and indicating the value of the purchased medicine;
- Medical referral to pass laboratory researches with indication of dates, titles and value of the each rendered service;
- Invoices of medical facilities for the rendered services (on the letter-head or with appropriate stamp) with indication of the family name of the Insured person, date of appeal, diagnosis, period of treatment, list of the rendered services itemized by dates and values and also the total sum subject to payment;
- Documents that confirm the fact of payment for medicine, treatment and other services.

9.6 Application and documents, indicated in point 9.5 of present Rules must be presented to the Insurer not later than 30 (thirty) calendar days since the moment of return of the Insured person from the travel, during which insurance accident occurred (by attaching original of official translation of documents, issued in any language, except Armenian, Russian and English).

9.7 Insurance compensation of the expenses of the Insured person is executed by the Insurer within 30 (thirty) working days since the moment of presenting documents indicated in point 9.5 of the Rules. The Insurer is entitled to check the presented documents, require information from the organization that has information on the circumstances of insurance accident, as well as to perform medical examination by the doctor of the Insurer. In case of necessity of receiving additional information on insurance accident, insurance compensation is executed within 30 (thirty) working days after receipt of all required documents by the Insurer. After insurance compensation execution, the originals of documents of the Insured person are not returned.

9.8 For compensation of expenses of the Insured person the Insurer accepts only paid invoices. In case of presenting not paid invoices, the Insured person is obliged to give written explanation.

9.9 Combination of procedures indicated in points 9.4.1 and 9.4.2 of the Rules is not admitted after coordination actions with the Service Centre or after choosing the medical facility.

9.10 In order to estimate the factual health condition of the Insured person, the Insurer is entitled to require and receive information on the health condition of the Insured person, upon the consent of the Insured person.

10. Basis for rejection of insurance compensation

10.1 The Insured is entitled to fully or partially reject insurance compensation execution in accordance with the insurance agreement, if:

10.1.1 the expenses occurred after termination (expiry of the Policy) of the insurance agreement, except cases foreseen in point 7.6 of present Rules and/or after return of the Insured person to the country of inhabitancy;

10.1.2 infringement of points 8.2, 8.3 and section 9 of present Rules took place;

10.1.3 presenting documents with deliberately false information to the Insurer, concerning the health of the Insured person or provided medical services and other associated services to him/her;

10.1.4 assistance (deliberate or by carelessness) in increase of the expenses, that are to be compensated by the Insurer in connection with insurance accident, or not performance of reasonable measures to reduction of losses.

10.2 The Insurer is entitled to fully or partially reject insurance compensation payment, if the accident was not recognized as insurance event in accordance with points 3.6.1 – 3.6.5 of present Rules.

10.3 The Insurer does not execute insurance compensation payment according to insurance agreement, if the insurance accident occurred beyond the period of insurance agreement validity.

10.4 The Insurer is entitled to fully or partially reject insurance compensation payment in other cases, stipulated in insurance agreement, present Rules and in cases, foreseen by the current legislation of the RA.

10.5 The decision to reject insurance compensation payment is informed to the Insured (Insured person) in written form by justification of the reasons of the rejection.

11. Termination of insurance agreement

11.1 Insurance agreement is terminated:

11.1.1 upon the expiry of its effectiveness (at 24 h of the day indicated as the day of expiry of insurance on insurance Policy or individual card);

11.1.2 in case of complete fulfillment of obligations under the agreement by the Insurer;

1.1.3 in other cases, foreseen by present Rules and current legislation of the RA.

11.2 Insurance agreement may be terminated ahead of schedule at any time by written notice of one of the Parties (including in connection with non-fulfillment of conditions of the insurance agreement by one of the Parties), by observance of requirements of the current legislation of the RA. In this case the return of insurance premium is executed in the following way:

11.2.1 in case of preterm termination of insurance agreement by the demand of the Insurer, the latest returns the received insurance premium for the unexpired period of insurance to the Insured, deducting executed expenses of the Insurer; if the demand of the Insurer is conditioned by non-fulfillment of the conditions of the insurance agreement by the Insured, insurance premium is not returned;

11.2.2 in case of preterm termination of insurance agreement by the demand of the Insured, who has given written notice to the Insurer before the day of expiry of the insurance agreement, the latest returns to the Insured the insurance premium for the unexpired period of insurance deducting expenses for execution of business administration of the Insurer in accordance with the current license; in case if the demand of the Insured is conditioned by the infringement of insurance agreement conditions by the Insurer, the latest returns the insurance premium in full amount;

11.2.3 insurance premium is not returned in case if the Insured person has not traveled to the country, indicated in insurance Policy, if the latest has valid visa for travel, or if the Insured person announces about his not traveling after expiry of insurance period, indicated in the insurance Policy.

11.3 In case of preterm termination of the insurance agreement, return of insurance premium is performed within 5 (five) banking days since the moment of receipt of written notice.

12. Regulation of disputes

Disputes in connection with insurance agreement are regulated through negotiation. In case of fail to come to an agreement, disputes are transferred to court in accordance with current legislation of the Republic of Armenia.