CONTENTS

PREAMPLE
INTRODUCTION

ARTICLE 1 Definitions
ARTICLE 2 Benefits
A Hospitalization
1. In Hospital Expenses (Reasonable and Customary Expenses)
a) Room and Board
b) Doctor's Surgeon's & Anaesthesiologist's Fees
c) Laboratory, Diagnostic & Paraclinical Examinations, drugs and other consumables.
d) Expenses prior to and Following hospitalization
e) Parental Accommodation Expenses
f) Hospitalization Abroad
2. Expenses incurred for Surgery not requiring Hospitalization
3. Emergency Ambulance Transfer towards Hospitalization
4. Childbirth Benefits
5. Organ Transplant
6. Home Nursing
7. Daily Hospitalization Allowance
B. Compensation Calculation
C. Probative Evidence
D. Consecutive Hospitalizations
ARTICLE 3 Application for Insurance
ARTICLE 4 Obligations of the Insured / Policy Owner
ARTICLE 5 Exclusions
ARTICLE 6 Obligations in the event of Hospitalization
ARTICLE 7 Termination of Validity
ARTICLE 8 Amendment of Cover due to Military Service
ARTICLE 9 Change of Policy Owner
ARTICLE 10 Policy Duration – Renewals
ARTICLE 11 Premiums and Premium Adjustment
ARTICLE 12 Waiver of Company Liability
ARTICLE 13 Subrogation
ARTICLE 14 Jurisdiction
ARTICLE 15 Cooling-Off Period
ARTICLE 16 Submission of Complaints
GENERAL MEDICAL EXAMINATIONS (CHECK-UP) SUPPLEMENTARY BENEFIT
1.0 Benefit
2.0 General Medical Examinations – Procedure to Follow
3.0 Premiums and Benefit Conditions Adjustment
4.0 Exclusions
5.0 Termination of Validity
OUT PATIENT CARE SUPPLEMENTARY BENEFIT
1.0 Benefit
1.1 Table of Benefits
1.2 Medical visits
1.3 Diagnostic Examinations
1.4 Prescribed Drugs
1.5 Physiotherapy
2.0 Percentage of Compensation
3.0 Submission of Claims
4.0 Medical Expenses not Covered
5.0 Premiums and Benefit Conditions Adjustment of the Supplementary Benefit
6.0 Termination of Validity
EMERGENCY TRAVEL ASSISTANCE

POLICY SCHEDULE
TABLE OF BENEFITS
ENDORSEMENT (WHERE APPLICABLE)

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In case of conflict between the English and the Greek text, only the Greek text will have legal validity. The English translation is only available for easier reference, also, any oral explanations which may have been given before or after the issue of this Policy have no legal validity whatsoever in case of conflict with any provision of the Greek written text.

In accordance with the terms of the present insurance policy and subject to its exclusions and conditions , “TRUST INTERNATIONAL INSURANCE CYPRUS LTD.” hereinafter called “the Company”, covers the necessary reasonable and customary hospitalization expenses which will incur during the period of validity of the present insurance policy, due to illness or accident of the insured person and his dependants, provided that the relevant insurance premiums have been paid and subject to the maximum Annual Limit of Liability of the Company per Treatment.

No insurance agent or representative is authorized to alter or modify this Insurance Policy, or to waive any limitation or provision of the Policy, or to extend the period for payment of the premium or to commit the Company in any way.

Chief Executive Officer

Issuing Officer

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GENERAL TERMS

Introduction

This Policy together with any supplementary benefits, endorsements, the application for insurance by the Policy Owner and the Insured Persons, as well as any medical questionnaires and medical reports, if such exist, shall form the overall agreement between the contracting parties and shall be considered as a single document.

Any amendment of the term of the present insurance policy will not be valid unless it is written and it bears the signature and stamp of the relevant amendment by an authorised employee of the company and the consent of the Policy Holder.

Article 1: Definitions

For the implementation of the terms of this policy, the following shall apply:

Illness Any disorder of the normal function of the organism of the insured which can be proved objectively, is not caused by accident, is medically certified, demands therapy and originates from causes which did not pre-exist at the time of contracting the present insurance policy, or have originated within thirty (30) days from the commencement of this policy, with the exception of any emergency within that period.

Accident Any bodily injury of the insured which can be proved objectively (is obvious on the external part of the body and/or can be medically proved) and results from an external, violent, fortuitous, and sudden cause, independent from the sufferer's will, and has occurred during the validity of the present cover.

Hospital/Clinic Every nursing institution, public or private, which operates legally for the treatment and therapy of patients and injured people, offers treatment on a twenty-four-hour basis and has the necessary equipment and means for diagnosis, therapy and generally for surgical operations. Convalescent homes, infirmaries, sanatoria, physiotherapy institutions, invalids rehabilitation units or clinics, old age homes, institutions for alcoholics or drug addicts as well as neurological and psychiatric clinics are not considered hospitals.

Ambulance A vehicle specially equipped with the necessary medical means and personnel, that is used for the transport of the Insured to the nearest Hospital.

Policy Holder The person who asks for and signs with the Company the present insurance contract, either for himself only, or for his dependants as well, and in whose name, the present insurance policy is issued.

Insured Persons These are the persons referred to in the Policy Schedule of the present contract, for whom the present insurance policy has been issued.

Insured Persons under this Policy, are considered, the Insured, as well as dependent members to his family, that is his spouse and their unmarried children the age of whom, on the commencement of the validity of the present cover, is for the insured and his wife less than sixty five (65) and for the children older than thirty (30) days and younger than eighteen (18) years.

The right of insurance may also be offered to the children of the insured aged 19 to 25, as long as they attend recognised educational institutions of secondary, higher or post-university education in Cyprus, or if they are carrying out their military service in the National Guard.

Age The age of the Insured attained at his last birthday.

Geographical Territory Cyprus

Country of Residence The Republic of Cyprus.

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Hospitalization The medical necessity for entry and stay of the insured on an inpatient basis in hospital for at least one (1) night and up to a maximum of 90 days , in order to undergo treatment which cannot be executed out of hospital. Hospitalisation implies health problems which do not come under the list of exclusions described herein below and which necessitate entry into hospital because they cannot be treated on an out-patient basis (e.g. at home, at out-patients-centres, with a short-term or middle-term stay in the emergency department) and the medical necessity for entry has been sufficiently substantiated.

Treating of such health problems must demand immediate surgical treatment or immediate curative (surgical or pharmaceutical) treatment, as well as the systematic attendance (reading or regulating crucial parameters of the patient at least 3 times daily) that will be substantiated from the hospitalisation file or the respective nursing forms (nursing diagrams etc.), which cannot be carried out in any environment other than that of a hospital.

The admission and stay of the Insured in a hospital on an inpatient basis for any period of time that exceeds that which is considered medically necessary for the event for which he is hospitalised, or for only undergoing diagnostic examinations, are not considered hospitalization.

Medical Necessity: Any health services offered, that are certified by the Company as medically suitable and necessary so as to:

- Face the insured's basic medical needs
- Be offered in the most appropriate and medically suitable way, taking into consideration both the quality and the cost of services rendered
- Be consistent with the diagnosis of the illness.
- Be indispensable for medical reasons and not for serving any other needs.
- Be provable through locally or internationally recognised protocols and scientific bibliography as being safe and effective in facing the specific health problems.

The medical necessity as interpreted in the present insurance policy refers to the cover of recognised expenses and is not necessarily identical to the attending physician's interpretation.

The medical suitability is based on prevailing standards of medical practice in relation to the specific pathological condition.

Medical Condition: Any disease, illness or injury which is not excluded by the terms of this Policy

Acute Condition: A medical condition or ill health crisis that is short – term and which has a specific time of healing.

Chronic Condition: A medical condition or ill health crisis that persists for a long period of time, persists indefinitely, is recurring or is incurable.

Year: Twelve calendar months from the Start Date of the policy or its Renewal Date.

Physician: A qualified medical practitioner who practices medicine under a license from the Cyprus medical association or the corresponding body of the country where he practices the medical profession. In no case can this person be the Insured or any member of his immediate family (first degree relatives).

Intensive Care Unit: The special unit / section in a Hospital, which accommodates for patients whose health condition requires constant medical monitoring and continuous nursing care from specialised nurses and all the necessary medical equipment. Standard hospital wards or any Private Standard or special monitoring rooms are not considered as Intensive Care Units.

Maximum Daily Room and Board Limit: The maximum daily amount the Company pays for Room and Board, as specified in the Policy Schedule, irrespective of the actual Hospital room type, the Insured chooses to make use of.

Treatment: Any scientifically assisted attempt for the surgical or medical-conservative treatment of any illness, injury or any other ailment to the Insured's health which has been medically certified and

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is considered necessary.

Excluded from the above is any treatment:

(a) that could or would normally be carried out on an out-patient basis.
(b) psychiatric / neurological
(c) the result of which is the relief of painful conditions and not their treatment e.g. haemodialysis, final cancer stages, etc.

Diagnostic tests are not considered treatment even if they take place in a Hospital.

Emergency: The need for the insured's immediate treatment in hospital due to illness or accident.

Start Date: The date on which cover under this Policy starts. Such date is the date on which the Company has accepted the risk and the first premium has been paid by the Insured.

Renewal Date: The anniversary date of this Policy on which the validity of this Policy is renewed for one more period (one year).

Reinstatement Date: The date on which the policy is reinstated back in force after being terminated for any reason.

Maximum Cover Per Illness: The maximum amount specified in the Policy Schedule that the Company would pay in total for treatment of an illness after the deduction of the deductible and the participation of the Insured.

Maximum Annual Cover Limit: The maximum amount specified in the policy Schedule that the Company would pay within a one – year period after the deduction of the deductible and the participation of the Insured.

Deductible: The part of the recognized expenses which must be paid by the Insured.

Participation of the Insured: The percentage of participation of the Insured in the recognized medical expenses.

Pre existing Condition: Any condition of health disorder known to the insured and/or the Policy Holder which has shown symptoms, has been diagnosed or constitutes the result of injury or illness for which treatment, medical or curative care was required prior to the date of the insured's participation entering into the present insurance policy.

Recognized Expenses*:* All medical expenses incurred for the treatment of the Insured which are covered by the provisions of this Policy.

Drugs: Medications and substances which have been clinically proved to be effective, and the administration of which is essential for the treatment or stability of any disease or bodily injury, or for the adjusting of vital substances and bodily functions. Only drugs prescribed by a qualified physician and are essential for the treatment of a covered disease or accident are covered under this policy. Any naturopathic or homoeopathic medications or mineral salts (other than those prescribed and administered during pregnancy or used to treat clinically evidenced significant vitamin loss syndrome) are not considered drugs. Any nutritional, dietary or remedial drugs prescribed for preventive reasons or are administered due to a habit, as well as any cosmetic products, even if they are medically introduced or prescribed, or recognised as having any therapeutic results, are not covered under this policy.

Charge: The reasonable and customary charge for treatment which is in line with the general price level and does not exceed the corresponding charge of other clinics or Hospitals of the same level and area for similar or comparable treatments or services to persons of the same sex and comparable ages and for similar accident or sickness.

Organ Transplant: The surgical procedure carried out for the transplant of the following organs and/or tissue for the heart, valves, lung, liver, pancreas, kidney, bone marrow, parathyroid, muscular tissue, skeletal tissue and cornea of the eye.

Words in the masculine gender also include the female gender and vice-versa and words in the singular number also include, where necessarily, the plural number and vice-versa.

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Article 2: Benefits

A. Hospitalization

The Company recognizes the following, provided all other policy conditions are met, if the Insured as a result of accident or sickness, has incurred hospitalisation expenses for his treatment:

1. **In Hospital Expenses (reasonable and customary charges)**

a) Room and Board: The charges levied by the Hospital and concern hospitalisation of the Insured, for Room and Board up to the Maximum Daily Limit for Room and Board shown in the Policy Schedule.

b) Doctor's, Surgeon's and anaesthesiologist's Fees: Fees paid to the Insured's treating physicians for services rendered, surgical procedures, or any other essential treatments of the Insured, taking place in hospital, during his hospitalisation.

If no surgical procedure is carried out, during the Insured Person's hospitalisation, the Company covers for doctor's visits during the hospitalization up to a maximum of one (1) such visit per day.

In the event that during hospitalization of the Insured, he undergoes two or more surgical procedures concurrently which are performed by the same surgeon, these are considered as one and the maximum amount payable under Surgeon's Fee is the amount corresponding to the most expensive surgical procedure performed.

c) Laboratory, Diagnostic and Para-clinical Examination, drugs and other consumables: Any necessary examinations carried out during the hospitalization, that are related to the cause for which hospitalization takes place, drugs administered while in hospital, blood transfusions, operating theatre expenses, medical supplies such as, splints, cast dressings, oxygen supply. Examinations carried out are included in the recognized expenses only if they are related to the main cause of the covered hospitalization. In the event that any examinations carried out are related to a secondary diagnosis, or are taking place for preventive purposes or for investigative purposes they are not covered. Any diagnostic examinations prescribed by the treating physician will only be included in the recognised expenses if they are accompanied by results and all other necessary documentation supporting the evidence of the medical condition and the need for hospitalization.

d. Pre and Post Hospitalization Expenses: If the insured receives treatment in hospital, the Company will also cover all necessary outpatients expenses which were carried out thirty (30) days prior to and thirty (30) days following the insured's hospitalization and are directly related to the insured's hospitalization up to the limit specified in the Policy Schedule.

The Company recognises restrictively the expenses that relate to the cause for which the insured was hospitalized and were realised for investigative purposes, treatment, medical and laboratory, ultra-sound and surgical examinations.

e) Parental Accommodation Expenses: The Company covers for accommodation expenses charged by the Hospital, of an accompanying adult escorting any minor covered under the Policy, aged twelve (12) years or less, who is hospitalized. Only expenses relating to Room and Board are covered for the accompanying adult.

f) Hospitalization Abroad: In the event that an Insured Person, is treated on an inpatient basis in a Hospital abroad, due to accident or illness, provided that in the case of illness the

hospitalization took place six (6) months after the Start Date of this Policy, the Company covers all necessary, incurred and recognized expenses, as interpreted in paragraph (1), **In Hospital Expenses (reasonable and customary charges),** and as included in the Policy Schedule.

The following prerequisites should be present for the approval and payment of expenses incurred for hospitalization abroad:

a. Referral by the treating physician and approval by the Company's Chief Medical Consultant that treatment should be carried out abroad. In the event of disagreement, an arbitrator (third physician) will be appointed by both physicians and the decision will be taken through majority vote.

b. For emergency treatment, while the Insured is travelling abroad for occupational or recreational reasons provided the duration of his trip does not exceed a period of two (2) months each time.

c. In the event that the Insured decides to be treated abroad. In such a case the expenses which might incur will be covered according to medical costs charged in Cyprus for similar events.

2. Expenses incurred for Surgery not requiring Hospitalization

In the event that the Insured undergoes surgery, without at least one (1) inpatient hospitalization which can be carried out on an outpatient basis, the Company recognises as hospitalization expenses, the expenses incurred for the operating theatre as well as surgeon's and anaesthetist's fees, according to paragraph 1(b) of this article and always up to the Maximum Cover per Illness or the Maximum Annual Cover Limit, whichever the case may be.

3. Emergency Ambulance Transfer towards Hospitalization.

In the event of an emergency incident in Cyprus, the Company recognises the expenses incurred for the transfer of the Insured by means of an ambulance, for hospitalization purposes. The Company covers up to the Maximum amount shown in the Policy Schedule, provided the following prerequisites are cumulatively met:

1. The emergency incident happens in an area where there is no suitable medical infrastructure to face it.
2. The urgency of transfer is confirmed and justified by medical opinion.
3. The hospitalization for which the transfer was effected is realised.
4. The transfer is carried out within twenty-four (24) hours from the occurrence of the incident.
5. The expenses incurred for the transfer are certified by presenting the transferor's original receipts.

4. Childbirth Benefits

In the event of a hospitalization taking place due to any of the following reasons and subject to the conditions described in detail below, the Company will pay an allowance as specified in the Policy Schedule:

a) Normal Delivery/Caesarean Section: Following the completion of twelve (12) months from the inception of the policy, the Company covers the insured with the allowance specified in the Policy Schedule, for the birth of a live or dead infant after the 24th week of pregnancy. For the payment of the allowance, the birth certificate and the Hospital exit slip must be submitted to the Company within 30 days from birth. No other compensation beyond this allowance is paid.

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b) Cervical cauterization or cryotherapy provided that it is justified by a PAP's test (smear).

c) Abortion supported by histological tests and provided that it was necessary for medical reasons.

5. Organ Transplant

Following the completion of twenty four (24) months from the inception of the policy, the Company covers the Insured for Organ Transplant.

This Benefit is payable only once throughout the duration of the policy and cannot be claimed again.

6. Home Nursing

The Company covers for Home Nursing expenses, which are deemed as medically necessary following the hospitalization of the Insured, provided these are rendered by a Registered Nurse, and up to the maximum limit set in the Policy Schedule and for a maximum number of twenty (20) visits.

7. Daily Hospitalization Allowance

The Company covers the Insured with a daily allowance as shown in the Policy Schedule and up to a maximum of twenty (20) overnight stays, for any hospitalization due to accident or illness, for which no treatment expenses are submitted by the Insured for compensation.

B. Compensation Calculation

The Company pays a compensation equal to the total hospitalization expenses incurred which have been recognised in accordance with paragraph A of Article 2 of the present Insurance Policy and up to the Maximum Annual Cover Limit, after the deduction of the deductible amount specified in the Policy Schedule or any other amount received or is entitled to receive from any other agency and after the application of the Insured's participation percentage.

Any compensation paid must relate to expenses incurred while this Policy is still in force, must be in accordance with the Benefits covered by the Policy for the treatment of a medical condition or of bodily injuries due to accident, must not fall within the Exclusions of this Policy and all provisions of this Policy must have been adhered to.

Any compensation is paid in Euro. Where covered expenses were paid in a currency other than the currency of the Republic the amount representing such expenses will be converted to the official currency of the Republic based on the official currency exchange rate on the date of payment of the compensation.

C. Probative Evidence

The following are probative evidence in respect of the expenses incurred for hospitalization purposes:

1. The original receipts and invoices for rendering services by nursing institutions and physicians.
2. The original certifications of any other insurance agency which show that the original receipts have been withheld by this agency on the basis of which part of the expenses incurred for hospitalization was paid to the insured, even if this is characterised as allowance.
3. The original receipts and invoices of pharmacies.

D. Consecutive Hospitalizations

Two or more treatments of the Insured, inclusive of any expenses incurred for emergency ambulance transfer, which are due to the same cause or to complications resulting from it, will be considered by the Company as one treatment, unless there is a time gap of more than ninety (90) days between them.

Article 3: Application for Insurance

The initial, as well as any subsequent application for insurance, must be submitted for any person applying for Insurance, in the special Company application form. The Company retains the right to request, at its own cost, from any person applying for insurance cover to undergo any necessary medical examinations, at a qualified physician designated by the Company.

The Company retains the right to reject any application for insurance, without having to justify its decision, or to accept it with revised conditions and terms, if it so deems necessary.

The collection of any premiums prior to the acceptance of the application for insurance does not constitute acceptance of the submitted application for insurance. In case that the Company rejects the application for insurance it must return the amount collected after deducting from it any expenses incurred for medical and other examinations.

Article 4: Obligations of the Insured / Policy Owner

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1. When applying for Insurance Cover, the Insured is obliged to provide the Company with full details concerning his state of health, his occupation and working conditions and in general to declare all events which are essential, for the Company to estimate correctly the risk it undertakes. All these details are included in the Application Form for Insurance Cover which constitutes an integral part of this contract.
2. Throughout the duration of the policy, the Insured or the Policy Owner, whichever the case may be, is obliged to declare to the Company any changes in his occupation, his working conditions, his capacity, as well as his work and home address.
3. The Insured is obliged throughout the entire duration of this Policy, to notify the Company for the existence of any other insurance cover against accident or sickness.
4. The Policy Owner is obliged to pay the premiums due to the Company according to the mode and method of payment agreed with the Company. Timely payment of premiums is the responsibility of the policy Owner and the Company is not obliged to provide reminders for any premiums due. Proof of payment is given by the issue of a Company receipt signed by an authorized representative of the Company. In case premiums are paid through direct debit or standing order from a banking institution, proof of payment is provided only through credit to the Company's bank account by the Bank of the Policy Owner.

Article 5: Exclusions

A. This policy does not cover hospitalization expenses due to accident or illness caused, directly or indirectly, exclusively or partly through:

1. The participation of the insured in flights in any aircraft or helicopter as well as hovercraft or balloon in any capacity. It is clarified that in accordance with the conditions of this policy, cover is provided for incidents that may occur when the insured is a passenger to any commercial airliner or scheduled chartered flights.
2. Parachuting
3. The use of explosives.
4. Attempted suicide or self-inflicted injury, irrespective of the mental state of the suicide.

B. This policy does not cover hospitalization expenses due to accident or illness caused during:

1. Participation of the insured in general, in professional or non-professional athletic meetings (sporting events or training) of recognised athletic clubs. (Non-professional athletes which are insured under this policy, will only be covered when taking part in non-professional athletic events without receiving any remuneration)
2. Participation of the insured specifically in professional or non-professional athletic boxing and wrestling meetings (sporting events or training).
3. Participation of the insured in professional or non-professional autonomous diving.
4. Participation of the insured in events, competitions, contests, acrobatics using mechanic means (cars, motor-cycles etc)

C. 1.Throughout the entire duration of this policy, hospitalization expenses caused due to illness which manifested itself within the first thirty (30) days from the inception of the policy or its reinstatement date (whichever is most recent) are excluded from this policy.

2. Hospitalization expenses incurred abroad, due to illness, are not covered, unless at least six (6) months have passed from the inception of the policy or its reinstatement date (whichever is the most recent).
3. Expenses incurred in relation to any treatment, examination, or medical deed which can be carried out on an outpatient basis without any danger to the Insured's health are not covered.
4. Expenses carried out for mental, psychic, nervous, neurovegetative disorders, neuroses, epileptic seizures, bulimia, anorexia, sleep apnoea, and psychiatric conditions or diseases, voluntary medication intake without physician's prescription, drug or toxic abuse, hallucinogens and psychotropic drugs, as well as alcohol abuse, committing or attempting to commit a crime, unjust attack or suicide attempt, alcoholism also including alcoholic hepatopathy, are not covered under this policy.
5. Expenses incurred for diagnostic examinations, carried out during hospitalization which is covered under this policy, but have no relation to the cause for which hospitalization took place, are not covered.
6. Expenses incurred for general medical check-ups are not covered under this policy.
7. Expenses incurred for recovery, rest therapies and geriatric therapy are not covered under this policy.
8. Expenses incurred for any form of therapy or surgical operations for the treatment of obesity are not covered under this policy.
9. Plastic surgery as well as other procedures carried out in general by plastic or aesthetic surgeons are not covered under this policy, unless these are required for the restoration of the consequences of an accident which is covered by this policy, (which can be proved through X-rays or other laboratory examinations), for which notification has been made to the Company in writing and has been approved by it, even though there may not be any claim for compensation. This therapy must take place within a period of six (6) months from the date of the accident.
10. Expenses incurred for dentistry or surgical therapy to the teeth sockets and gums as well as therapy of the Centrum of temporo mandibular joints (TMJ), is not covered by this Policy, unless such therapy is necessary as a result of an

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accident.

11. Acquired Immune Deficiency Syndrome (AIDS) and its complications are not covered by this Policy.

12. Expenses for purchasing and placing technical prosthetic body parts, corrective apparatus and equipment supportive of their functioning are not covered by this policy. The following are exceptionally covered: exclusively and only, the expenses for purchasing and placing a corneal implant, intraocular lens implant, heart valve arteries implant, peacemaker, defibrillator and osteosynthesis materials, provided their fixing is indispensable due to an accident or illness which occurred during the validity of this policy and provided the approval, of the Company, in advance, will precede.

13. Removal of moles or skin tumours is not covered by this policy, unless malignancy has been proved following histological examination. In the event that such removal will be carried out by means of laser treatment, this procedure must take place only after a histological examination has been carried out proving the malignancy.

14. Any treatment, examination and medical procedures that can take place out-of-hospital are not covered by this policy.

15. Any treatment or surgery to correct optical refracting anomalies or hearing sharpness are not covered by this policy, even if they are the result of accident.

16. Any treatment related to sex change or required directly or indirectly due to this, as well as treatment of sexual impotence or sexual disfunctionality and their implications are not covered by this policy.

17. Hospitalization for rehabilitation purposes is not covered by this policy, with the exception of cases where:

- It constitutes an inseparable part of the treatment and
- It is performed by a physician specialized in rehabilitation, and
- It takes place in a recognized Hospital or rehabilitation center, and
- The cost has been approved by the Company in writing prior to the commencement of rehabilitation.

18. Charges for special in hospital treatment are not covered by this policy, unless the Company has agreed in advance that such treatment is suitable and necessary.

19. Charges for curative springs (hot springs), stay or treatment in convalescent homes, sanatoriums, spa centres, hydrotherapy centres and other similar establishments are not covered by this policy, even if these establishments have been registered as hospitals.

20. Charges resulting from medical practice which is not recognized as such in Cyprus and / or charges that result from the insured's request are not covered by this policy.

21. Expenses resulting from or related to regular or long – term haemodialysis, chronic renal failure, medical articles, artificial body parts and appliances, are not covered by this policy.

22. Charges relating to the preparation of medical reports or for the completion of the Claim Forms or Applications for Insurance or any part thereof are not covered by this policy.

23. Treatment for, or related to, developmental problems in children, whether physiological or psychological, or related to learning difficulties, is not covered by this policy.

24. Treatment that has not been proven to be effective or is still at an experimental stage (Experimental Treatment) is not covered by this policy. However, the Company will proceed with payment if, prior to the commencement of the treatment, such treatment is accepted by a recognized medical organization as suitable and the Company has reached an agreement with the treating physician on his fees.

25. Treatment concerning sexually transmitted diseases, such as, but not limited to Chlamydia, herpes of the genital system, syphilis, gonorrhoea or their implications is not covered by this policy.

D. This policy does not cover hospitalization expenses as a result of any cause relating totally or partially, directly or indirectly with any or all of the following reasons, conditions or treatments:

1. Hereditary conditions, congenital conditions as well as any pre-existing to this policy conditions, or bodily injuries as well as their recurrences and complications, for which medication, advice or treatment was received, or for which there were symptoms, it was known or would reasonably must have been known to the Insured, irrespective of whether the condition had been diagnosed prior to the Start date of the Policy or not.
2. Direct or indirect epidemic consequences resulting from war, earthquake, flood or other large scale natural disasters.

3. Any diagnostic examinations, medication or treatment related to infertility or insemination

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E. This policy does not cover hospitalization expenses or treatment, within the first twelve (12) months of the policy duration or its reinstatement date, for any of the following conditions even if they are not pre-existing:

1. Treatments concerning afflictions of meniscus and ligaments, herniated intervertebral disc, fibrous anal rapture and their complications, irrespective of whether they result from an accident, even if the case has been characterised as an accident by court judgement.
2. Haemorrhoids, anal fissure, fistula, varicose veins as well as nose diaphragm and their complications.
3. Tonsillectomy or adenoid germinations, all kinds of hernia as well as conditions relating to the genital organs.
4. General investigative gynaecological surgery, whether this be carried out by laparoscopic means or not. These are only covered where the disease can be proved histology tests as well as laparoscopic tapes.
5. Any expenses relating to pregnancy and childbirth

F. This Policy does not cover hospitalization expenses incurred within the first two (2) years of the policy duration or its reinstatement date, for any rheumatic, degenerative conditions of the bones and or joints.

G. This Policy does not cover for any hospitalization expenses paid to the insured from any other insurance carrier**.**

H. This Policy does not cover for any hospitalization expenses incurred, relating to charges which are in excess of the amounts that in the opinion of the Company constitute reasonable and customary charges for similar or comparable treatment or services to persons of the same sex and of comparable age and for similar accident or sickness.

I. This Policy does not cover any hospitalization expenses incurred or resulted from events that occurred during any period for which the premium had not been not paid within the grace period specified in Article 11. The collection of the premium in any subsequent period does not waive this exclusion under any circumstances.

K. Furthermore, the Company is not liable, according to the conditions of this Policy, for expenses incurred due to any illness or accident which occurs or takes place or results directly or indirectly from any of the following occurrences:
1. War, invasion, act of foreign power, enemy acts (whether war be declared or not), civil war, riot, rebellion, nuclear biological or chemical act or terrorism, revolting or overtaking of the government by force, or military action or usurpation of power, or the participation of the Insured in any illegal acts. Ionizing radiation or contamination by radioactivity from any nuclear fuel, or from any nuclear waste or from the combustion of any nuclear material.
2. Through radioactive, toxic, explosive or any other perilous capacity of any nuclear explosive set or any nuclear component part thereof.
3. Naval, or military, or air force, or policy operations.
4. Any deliberate self-inflicted injury, suicide or attempt to commit suicide, use of drugs, alcohol abuse, venereal diseases, intoxication, or any diseases resulting from chronic alcoholism.

Article 6: Obligations in the event of Hospitalization.

The Insured Person is obliged to inform the Company in writing, prior to any scheduled Hospital/Clinic admission, taking place, for himself or for any of his dependents. He is further obliged to deposit to the Company's Head Office, a written notice for any scheduled Hospital admission taking place for himself or any of his dependents within seven (7) days from the date of the accident or the occurrence of the illness. Notification to the Company, in the case of a scheduled Hospital admission, must be made prior to the patient's admission and in any case not after the patient's discharge from Hospital. If the Company does not receive the notification within this time limit, it is exempted from any obligation deriving from this policy unless the Insured or Policy Holder proves that their timely declaration was prevented by objective difficulties and that they released it as soon as these difficulties were overcome and that the Company had the opportunity to verify the real circumstances of the accident or illness.

The Insured and/or the Policy Holder are obliged to authorise the Company to proceed to any investigation, if need be, by any of its authorised personnel, of the Insured's whole medical file. To this end, the Insured and/or the Policy Holder authorise the Company to receive all necessary information for every medical document relating to the health of the

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Insured and, they are equally obliged to provide all the necessary information and submit data and documents relating to the circumstances and the consequences of the occurrence of the risk, as requested by the Company.

All expenses incurred for the collection and submission of all substantiating documents required for compensation shall burden the Insured. All substantiating documents should be validated and all invoices and payment receipts should be in originals.

In case of hospitalization of the insured abroad, the Company may upon its discretion ask the Insured and/or the Policy Owner to present:

(a) Substantiating documents regarding hospitalization expenses and hospitalization justifications, validated from the nearest Cyprus consular authority as well as,
(b) An official translation thereof.

All above-mentioned documents (if requested), attached with the claim form must be submitted to the Company within 45 days from the date of the occurrence which gave rise to the need for hospitalization. Any possible violation of this time limit will lead to rejection of the claim.

The Company owns the right to appoint a physician of its choice in order to investigate for the assessment of the claim. Upon payment of the claim, all documents and other evidence submitted, become the property of the Company.

Article 7: Termination of Validity

This policy ceases to be valid, without notification, when one of the following conditions occurs:
(a) With the expiry or the cancellation of this policy.
(b) With the non payment of premiums due for this policy.
(c) For the children of the Insured that are covered under this policy as dependent members, this policy ceases to be valid on the policy anniversary following their eighteenth (18) birthday, or their twenty fifth (25) birthday if they are students in recognised schools of secondary or tertiary education, or from the date of their marriage, if it precedes their 18th or 25thbirthday, whichever the case bay be, or while they are carrying out their military service at the National Guard.
(d) Following a complaint, filed by the Insured or Policy Holder, for breach of material conditions of this policy.

Insurance premiums which were paid for this policy, after the termination of its validity for any reason, do not create any obligation to the Company other than the interest-free refund of the amount.

Article 8: Amendment of Cover due to Military Service

This policy will still provide cover to any Insured Person throughout his entire military service to the National Guard, provided that any incident, for which he needs to be hospitalized, did not happen during the performance of his duties in the National Guard.

Article 9: Change of Policy Owner

If the Policy Holder/Insured dies during the validity of this Policy, the Company, grants to one of the adult dependents, the right to become the new Policy Holder, provided the respective premiums are paid.

The right can be exercised through a written application which must be submitted to the Company within thirty (30) days from the date of the insured's death.

Article 10: Policy Duration - Renewals

This Policy has an annual duration and the Start Date is the date specified on the Policy Schedule. This Policy is renewed on each anniversary for a period of one more year, provided that the specific plan is still offered by the Company and so long as the contract of insurance has not been denunciated in writing either by the Company or by the Policy Holder.

The Company retains the right not to renew the policy without any notification and/or grace period, under the following circumstances:
i. If premiums are not paid in accordance with the provisions of Article 11.
ii. The Policy Holder and/or the Insured have made false declarations or have failed to disclose material information, which if known to the Company at the time of application submission, the Company would not have accepted the risk for insurance or would have accepted it under certain conditions.

DRAFT

On each renewal date, the Company retains the right to renew a policy without any further consent on behalf of the Policy Holder.

The Company retains the right to revise or alter the provisions, covers and premiums of the policy and any such revisions or alterations become effective on the renewal of the Policy.

Article 11: Premiums and Premium Adjustment

On the commencement of this policy, the Company will collect the insurance premium corresponding to the age of the insured, in accordance with the prevailing pricing rules in force at the time.

Premiums are paid to the Company in accordance to the method and frequency agreed in writing at the beginning of each period of insurance. A thirty (30) days grace period is provided (interest-free) for the payment of premiums due, with the exclusion of the first premium.

(a)On every policy anniversary, the Company will adjust the premium on the basis of the insured's new age.
(b)On every policy anniversary, the Company also reserves the right to proceed to an additional premium re-adjustment, if the actuarial parameters taken into consideration for the calculation of the original premium change.

The Company may suspend part or all of this readjustment in favour of the insured, reserving however the right to implement it cumulatively, at its discretion, on a later anniversary.

Article 12: Company's discharge of Liability

The Company is discharged from any liability for the payment of any expenses if the Insured:
1. Makes false declarations or fails to disclose material information or events known to him, which if known to the Company at the time of application submission, the Company would not have agreed to the Insurance or would have accepted it under certain conditions.
2. Alone, or in collaboration with others, attempts to receive compensation from the Company using deception or fraud.
3. Fails to declare any changes concerning the information he declared to the Company on his Application for Insurance, thereby, increasing the risks associated with the insurance cover.
4. Declines or omits to undergo medical examinations by the Company Doctor(s).
5. Refuses to submit reports, certificates and information requested by the Company.

Article 13: **Subrogation**

In the event that any compensation payments are made, the Insured assigns any right, to legally seek compensation from any third party directly or indirectly responsible for the claim, to the Company. The Policy Owner or the Insured assign to the Company any legal right and provide the Company with every possible support in case that the Company exercises the right of subrogation.

Article 14: Jurisdiction

This insurance policy is governed and construed in accordance with the laws of the Republic of Cyprus. The Courts of the Republic of Cyprus have jurisdiction for any difference between the contracting parties that derives from the present contract.

Where a conflict might arise between the conditions of the contract and any laws of the Republic of Cyprus which have become valid after the commencement of the validity of the present contract, the Company reserves the right to amend the conditions of this contract from the date of the commencement of the validity of these laws.

Article 15: Cooling-Off Period
If for any reason the Insured is not satisfied with this policy and subject to the provisions of article 134(2) of the Exercising of Insurance Business and Related Issues Law of 2002 – 2004, he is entitled to request the cancel of this policy from inception, within thirty (30) days from its receipt, by completing and submitting or mailing through registered mail to the Company the relevant document Notification of Cancellation, which the Company has included in his Policy documents.

Any Notification of Cancellation submitted or posted to the Company after the above time limit, does not render the Company liable to accept it. In the event of cancelling the Policy within the above time limit, this will be cancelled from

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inception and any amount collected in relation to the policy must be refunded the latest within one month of the receipt of the relevant notification. Any premiums received by the Company with the original application for insurance must be refunded, after deducting any actual medical and any other expenses that the Company may have paid in relation to the acceptance of the risk and the contracting of the policy.

Article 16: Submission of Complaints

In the event that the Policy Owner or the Insured are not satisfied for any reason by the Company, the Company wishes to become aware of it. The Company is obliged to investigate and respond within a reasonable time period to all written complaints submitted to the head office of the Company and addressed to the Complaints Officer of the Company at the address listed below. Investigation of a complaint by the Company necessarily implies a written submission, full details of the complainant and the policy and full description of the circumstances which led the complainant to the submission of the complaint.

The provisions of the above paragraph do not, in any way, affect the right of the Policy Owner or the Insured to seek legal justice.

TRUST INTERNATIONAL INSURANCE COMPANY (CYPRUS) LTD.
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2nd Floor,
2048, Strovolos, Cyprus.

P.O.B. 25690,
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DRAFT

General Medical Examinations (Check-Up) Supplementary Benefit

This benefit is incorporated in the basic insurance policy and is valid only if included as a Supplementary Benefit in the Policy Schedule.

It is clarified that the terms and conditions of the basic plan apply and are practiced relatively for this supplementary benefit too.

1.0 Benefit

With this supplementary benefit the Company covers restrictively, the Insured and his spouse, provided that the spouse is also covered by the basic insurance contract, for general medical examinations (check-up), as specified in the policy schedule, which can only be carried out once in every policy year for each of them, with the Company reserving the right to amend them at its discretion.

A prerequisite for the cover of the medical examinations is that at least one full year's premiums have been paid for this policy as well as the first instalment following the renewal of the policy, and that the policy is in force at the time the medical examinations are carried out. Each subsequent medical examination must have a 12 month interval from the previous one.

The General Medical Examinations should be carried out exclusively by Medical Associates appointed by the Company.

2.0 General Medical Examinations - Procedure to follow

If the Insured wishes to carry out his General Medical Examinations (Check-Up), he must do so by contacting any of the Medical Associates appointed by the Company, in order to arrange a date for the medical examinations to be carried out. The Medical Associate will, in turn, contact the Company, in order to verify that the premiums are paid and that the specific benefit is in force, before he carried out the examinations.

The Company will pay the appointed Medical Associate, after receiving all the necessary relevant original receipts, the costs incurred for the general medical examinations, on behalf of the Insured.

3.0 Premiums and Benefit Conditions Adjustment

The Company reserves the right to alter the conditions, benefits and premiums of this Supplementary Benefit and any such alterations become effective on the renewal of the Benefit.

On every policy anniversary, the Company also reserves the right to proceed to an additional premium readjustment, if the actuarial parameters taken into consideration for the calculation of the original premium, change.

The Company may suspend part or all of this readjustment in favour of the insured, reserving however the right to implement it cumulatively, at its discretion, on a later anniversary.

4.0 Exclusions

This Supplementary Benefit does not cover:

a. General Medical Examinations carried out in anywhere or by anyone other than the Company's Appointed Medical Associate.

b. Any examinations or laboratory tests other than the ones specified in the Policy Schedule.

5.0 Termination of the Supplementary Benefit

This Supplementary Benefit ceases to be valid, when one of the following conditions occurs:

(a) With the expiry or the cancellation of the Basic policy.

(b) Following the renunciation by the Insured or by the Policy Holder by the Company, of this Supplementary Benefit.

(c) With the non timely payment of premiums.

(d) Following the renunciation by the Insured or Policy Holder, for breach of vital terms of the present Policy.

DRAFT

Out Patient Care Supplementary Benefit

This benefit is incorporated in the basic policy conditions and is valid only if included as a Supplementary Benefit in the Policy Schedule.

It is clarified that the terms and conditions of the basic plan apply and are practiced relatively this supplementary benefit too.

1.0 Benefit
This supplementary benefit covers all necessary, reasonable and customary medical expenses due to illness or accident, incurred on an outpatient basis in Cyprus, by the Insured and any of his dependents (provided that they are also covered by this Policy). It also covers all necessary, reasonable and customary medical expenses incurred on an outpatient basis abroad, provided that the person covered, is on a professional or recreational trip, for a period which does not exceed thirty (30) days each time.

The cover provided by this Supplementary Benefit is according to the Table of Benefits, and compensation paid is calculated as a percentage of the actual and realised expenses, as stated in the above mentioned Table.

1.1 Table of Benefits
The Company recognises and pays for all actual expenses covered under this Supplementary Benefit up to a maximum amount per Insured Person as stated in the Table of Benefits of this Policy, which corresponds to the Supplementary Benefit Plan that is included in the Policy Schedule.

1.2 Medical Visits
This Supplementary Benefit covers the fees for visits to doctors carried out in Cyprus and abroad, according to article 1.0 Benefit and up to the maximum amount per visit, that which is stated in the Table of Benefits.

1.3 Diagnostic Examinations
This Supplementary Benefit covers all recognised, reasonable and customary expenses incurred, following a doctor's referral, for x-rays, laboratory tests and other diagnostic examination that are directly related to the main cause of the medical condition. The cover provided is according to article 1.0 Benefit and up to a maximum annual limit, as stated in the Table of Benefits.

1.4 Prescribed Drugs
This Supplementary Benefit covers all expenses incurred for drugs, prescribed by the treating doctor, which are necessary for the treatment of the diagnosed condition, as per article 1.0 Benefit and up to a maximum annual limit, as stated in the Table of Benefits.

1.5 Physiotherapy
This Supplementary Benefit covers the expenses incurred for physiotherapy sessions that are necessary restrictively for the repair of bodily injury caused by accident, provided they are carried out following the treating doctor's referral, and they are directly related with the main cause of the accident, as per article 1.0 Benefit and up to a maximum annual limit, as stated in the Table of Benefits.

2.0 Percentage of Compensation
The Company compensates the Insured and his dependents (provided that they are also covered under this Policy), with an amount equal to the sum of all actual and realised expenses, up to a maximum annual liability limit, following the deduction of any other amount the Insured has collected, or is entitled to collect from any other Insurer and after applying the indicated co-insurance percentage of the Insured.

3.0 Submission of Claims
In the event that within the validity of his cover, the Insured or any of his dependents (provided that they are also covered under this Policy) suffers from an illness or injury entailing the materialization of outpatient medical expenses, the Company shall pay, following the submission of all necessary evidential documentation, that is, original payment receipts and invoices and a written claim notification, all realised expenses according to article 1.0 Benefit of this cover.

All the above, must be submitted to the Company's Head Office by the Insured, within thirty (30) days from the date he has carried out the medical expenses. If the Company does not receive the above, within this time limit, it is exempted from any obligation deriving from this Benefit.

DRAFT

4.0 Medical Expenses Not Covered.

This Supplementary Benefit does not cover expenses deriving directly or indirectly for the following circumstances:

- Preventive medical examinations (check-ups) or routine examinations, vaccinations, smear-tests, stress-tests, osteoporosis-tests, or preventive treatments.
- Expenses paid by any main body or subsidiary insurer.
- Expenses incurred for the purchase of reading glasses, or contact lenses or hearing aids.
- Ophthalmology routine tests, vision tests, hearing tests.
- Expenses incurred for the purchase of cosmetics, soaps of any sort, hair care products, antiseptic products as well as any expenses incurred for the treatment of allergies.
- Expenses incurred for the purchase of vitamins and baby food.
- Dental treatment other than the necessary for the restoration of any damage caused by accident, all medication relating to the treatment of teeth and gums.
- Products intended for for cosmetic reasons, as well as products relating to acme treatment of any sort, dry skin treatment or nails therapy.
- Expenses incurred for the treatment of alcoholism and its complications, use of drugs and detox treatment, Acquired Immunology Deficiency Syndrome (AIDS)
- Expenses incurred for the treatment of neurological, psychiatric conditions, mental disorders, depression / anxiety syndrome, as well as their complications, congenital conditions, epileptic seizures.
- Expenses incurred for bodily injury caused directly or indirectly as a result of a suicide attempt, irrespective of the mental state of the suicide.
- Expenses incurred due to pregnancy, miscarriage, abortion as well as any complications or after effects.
- Medication or treatment relating to sterility or fertility.
- Expenses incurred for gynaecological problems, unless these manifested themselves at least twelve (12) months after the commencement of this Benefit or its Reinstatement Date.
- Physiotherapy, other than that intended for the restoration of bodily injury as a result of an accident.
- Expenses incurred for the treatment of rheumatism, arthritis, back pain, sciatica, muscular pain, neck pain.
- Expenses incurred for pre existing conditions.
- Expenses incurred for the treatment of congenital conditions.
- Expenses for treatments that go beyond the framework of conventional medicine.
- Expenses incurred for which no legitimate payment receipt and invoice have been issued.
- Expenses incurred for the treatment of hormone disorders, metabolic disorders, or menstrual cycle disorders.
- Charges which exceed such amounts which in the opinion of the Company constitute reasonable and customary expenses for similar or comparable treatment or services to persons of the same sex and of comparable age and for similar accident or sickness.

5.0 Premiums and Benefit Conditions Adjustment

The Company reserves the right to alter the conditions, benefits and premiums of this Supplementary Benefit and any such alterations become effective on the renewal of the Benefit.

On each policy anniversary, the Company will adjust the premium based on the Insured's new age.

On every policy anniversary, the Company also reserves the right to proceed to an additional premium readjustment, if the actuarial parameters taken into consideration for the calculation of the original premium change.

The Company may suspend part or all of this readjustment in favour of the insured, reserving however the right to implement it cumulatively, at its discretion, on a later anniversary.

6.0 Termination of Validity

This Supplementary Benefit ceases to be valid, when one of the following conditions occurs:

(a) With the expiry or the cancellation of the Basic policy to which this is a supplementary benefit, for any reason.

(b) Following a renunciation, filed by the Insured or by the Policy Holder, of this Supplementary Benefit.

(c) With the non timely payment of premiums.

(d) For the Insured and his spouse, with the Policy Anniversary which follows the completion of their sixty fifth (65th) year of age.

(e) For the dependent children that are insured under this benefit, with their marriage, or the commencement of their military service to the National Guard, or on the Policy Anniversary which follows the completion of their eighteenth (18) year of age, or the twenty fifth (25th) if they are students in recognised schools of secondary or tertiary education.

Premiums which were paid for this Supplementary Benefit, after the termination of its validity for any reason, do not create any obligation to the Company other than the interest-free refund of the amount.

DRAFT

“EMERGENCY TRAVEL ASSISTANCE" INSURANCE TERMS

The contract is extended in order to provide Travel Assistance during the Insured’s Trip outside of the Republic of Cyprus, however always without prejudice to the terms, conditions and exclusions included in this endorsement, as follows:

A. DURATION AND TERRITORIAL LIMITS OF THE INSURANCE

The insurance cover and assistance are provided 24/7 365 days worldwide, provided that the Insured is on a Trip outside of the Republic of Cyprus and for a continuous period up to sixty (60) days.

B. DEFINITIONS

The following words and phrases shall apply solely for the purposes of this endorsement and shall be interpreted as follows wherever they appear:

Illness

This is means only sudden and unforeseen illness that manifests itself for the first time during the Trip and is not due to a chronic ailment.

Death

This means the Insured's death due to illness or accident, which Death occurs outside of the Republic of Cyprus during the insurance period and is not due to a pre-existing illness or suicide or a suicide attempt.

Medical Costs

These are the necessary costs incurred for the treatment of the Insured's bodily injury or illness and include medical visits, surgical operations, x-rays, medicine and general costs at the Hospital or Clinic abroad, which arise and are payable abroad, excluding any dental treatment or dental treatment costs other than those incurred for the provision of first aid.

Trip

This is every instance of travel outside of the Republic of Cyprus by ship, aeroplane or other mode of transport, as well as the stay outside of Cyprus for a period up to 60 consecutive days.

Permanent Residence

This is the Insured's residence at his/her usual country of residence.

Country of Usual Residence

This means Cyprus.

C. TRAVEL ASSISTANCE PROVIDED

The Company must provide Travel Assistance to the Insured when he/she finds himself/herself in distress according to the following provisions.

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The cover includes:

1. Transportation or repatriation for health reasons in case of Illness or Accident of the Insured during the Trip

In the case of an Accident or Illness, the Company will see to the Insured's transportation to a suitable health centre within the Covered Area or to his/her repatriation to a suitable health centre in his Country of Usual Residence.

The Company will decide, at its own discretion and with the aid of its medical team, the health centre to which the Insured is to be transported or repatriated. In the case of repatriation, the Company will determine whether repatriation is necessary, taking account of the availability of healthcare in the Covered Area, the Doctor's opinion, the availability of suitable means of transport and the condition of the Insured's health.

In the case of Accidents or Illnesses which are not Serious Accidents or Serious Illnesses and which, according to the Company's medical team, do not require repatriation, the Insured will be transported to a suitable health centre in the Covered Area. This transportation will be carried out by ambulance or by another appropriate mode of transport (while taking the condition of the Insured's health into account).

If the Company's medical team determines that the Insured's transportation or repatriation requires travel by air, then the transportation or repatriation will be carried out by a specially equipped air ambulance, provided that the Covered Area is a country of the European Economic Area or a country bordering the Mediterranean Sea.

Any transportation or repatriation by a specially equipped air ambulance is expressly excluded if the Covered Area is outside of the European Economic Area and is not a country bordering the Mediterranean Sea.

2. Medical assistance in case of Illness or Accident of the Insured during the Trip abroad

In the case of Illness or Accident of the Insured during his/her Trip outside of the his/her Country of Usual Residence, the Insured will be entitled to claim an amount up to € 10,000 to cover the cost of any clinical expenses, surgical operations, doctor's fees, nurses' fees and medicine prescribed by a Doctor.

The Company's medical team will be in contact over the telephone with the medical centre and with the Doctor in order to ensure that the Insured received appropriate medical care.

Even if the Insured submits a claim based on this paragraph, the Insured will also have to submit a claim for any benefits (social security benefits or otherwise) which he/she may be entitled to under the social security system of his Country of Usual Residence. The Company may reclaim from the Insured any amounts paid to the Insured by the social security system. If the Insured fails to submit a claim to the social security authorities or fails to disclose any amount he/she receives from the social security authorities, any claim he/she submits under this paragraph may be rejected.

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3. Extension of the Insured's stay due to injury or illness
The Company will cover the Insured's stay at a hotel if, due to illness or bodily injury during the Trip, the extension of his/her stay there is deemed necessary by a doctor. These expenses are limited to € 100 per day and for up to five (5) days.

4. Visit to the place of treatment by a family member of the Insured
If the Insured who has sustained an injury or has fallen ill during the Trip needs to be hospitalised for a period longer than five (5) days, the Company will cover the following for one family member of or other person chosen by the Insured:

a. the cost of the travel to the place of treatment and back;

b. the cost of staying at a hotel near the place of treatment, up to € 100 per day and for up to ten (10) days.

5. Transportation or Return of the persons accompanying the Insured.

If the Insured Event described in paragraph 1 above occurs, the Company will undertake the transportation of the Insured's first-degree relatives accompanying him/her, up to five persons in total, to the Country of Usual Residence or to the location where the Insured is to be hospitalised.

Moreover, if the insured event occurs for the Insured and an insured person accompanying the Insured is under the age of fifteen (15) and there is no-one else to accompany that person, the Company will provide a suitable escort during the journey to the permanent resident or to the place of treatment.

6.Forwarding of urgent messages
The Company undertakes to forward urgent or necessary messages to and from the Insured regarding each of the events related to the services described in this endorsement.

7. Transportation of the deceased Insured's body.
In the case of <u>death</u> of the Insured, the Company will undertake the cost of the necessary procedures for the body's repatriation and transportation to the Insured's permanent place of residence.

8. Urgent transportation due to an event in the Country of Usual Residence which affects the usual place of residence or the business premises of the Insured

The Company will bear the cost of an urgent transportation to the Country of Usual Residence in the case of:

- a burglary in which the doors or windows of the building were forced open or broken; or

- fire or explosion,

due to which the Insured's usual place of residence or any business premises belonging to or rented by the Insured have become uninhabitable or face a significant risk of sustaining further damage and, therefore, the event requires the Insured's immediate attention and creates the need for him/her to travel to these locations, **provided that the Insured is unable to travel using his own means of transport or those he/she has booked for the Trip**.

The Insured must submit to the Company copies of all the certificates (including - listed indicatively and not restrictively – the fire report, police report and insurance report) regarding the burglary, fire or explosion that caused the curtailment of the Trip.

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9. Money Guarantee for legal procedures

1a. The Company undertakes the obligation to pay the amounts required as a deposit to third parties to guarantee the payment of legal fees for criminal proceedings due to a motor accident in which the Insured was involved during the Trip, up to € 1,000.

1b. The Company undertakes the obligation to pay the amounts required as a guarantee for the temporary release of the Insured if, during the Trip, he/she becomes involved in motor accidents which give rise to criminal liability of the Insured, up to € 1,000.

2. The Insured must reimburse the amounts paid by the Company under cases (1a) and (1b) above within three (3) months of the amounts being paid by the Company.

D. CLARIFICATIONS – SPECIAL CASES

1. **a)** This cover shall not, in any case, be considered to grant to the Insured the right to request or agree to the provision of services from any third party and to then claim from the Company the amount he/she paid or promised.

b) The aforementioned insurance cover is provided in kind (not in cash) through the Company's partners in Cyprus and in the other countries within the territorial limit of the insurance, except where the Company is unable to serve the Insured through its partner network due to force majeure. In this case, the Company will ask the Insured to pay the cost of the necessary services and to then send the corresponding receipts and invoices to the Company so that he/she can receive compensation. In all cases, such expenses will only be reimbursed if they have been approved by the Company in advance.

2. The Company reserves the right:

a. to use the personnel and equipment it chooses and to collaborate with natural or legal persons that use these means which have been selected at the Company's own discretion.

b. to use the means which it deems to be most expedient for dealing with each assistance case covered under this insurance.

E. EXCEPTIONS

The cover does not apply to the following cases:

a. Where the request for assistance is submitted during a period of war and/or is directly or indirectly related to a declared or undeclared war, to hostile operations, revolts, civil unrest or insurrection.

b. Where the event for which assistance is requested occurred before the insurance cover's effective date.

c. For damage due to earthquakes and natural phenomena in general which can cause large-scale destruction, provided that smooth traffic conditions and access have not yet been restored.

d. For illnesses resulting from chronic conditions or ailments which existed before the start of the Trip.

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e. For suicide, suicide attempts or self-injury by the Insured, as well as death or injury which was the direct or indirect result of actions of the Insured which put him/her at increased risk.

f. For the consequences of voluntary consumption of alcohol, toxic substances, drugs or medicine taken without a doctor's prescription or in an excessive dose.

g. For costs where the assistance consists of the procurement or fitting of artificial body parts or eyeglasses and also in the case of pregnancy complications, labour or the manifestation of any kind of psychological illness or mental disorder in general.

h. For the consequences of the Insured's participation in any kind of race (whether official or unofficial).

F. OBLIGATIONS OF THE INSURED

As soon as an event that entitles the Insured to services under this endorsement occurs, the Insured must:

a. immediately call the Assistance Centre on (+30) 210 6504041 – which number has been communicated to him/her – and must request the corresponding assistance after stating his/her full name and Insurance Policy number and must fully inform the Company about the actual facts of the insured event and must accurately and precisely specify the location where he/she is and the kind of services required. This obligation of the Insured is a substantial term of this Contract and its performance is a condition precedent for the existence of any liability of the Company.

b. obtain the Company's consent before taking any measures which involve any costs or expenses. The Insured must not in any case negotiate, accept or reject any third-party claims regarding the loss without the Company's approval.

c. Use all the means available in order to mitigate the consequences of the loss and refrain from taking actions which may unreasonably increase the cost of providing the assistance. Any failure of the Insured to do so will entitle the Company to reduce the services it provides accordingly, taking into account the gravity of the losses caused by the Insured and the extent to which the Insured is responsible for those. If this failure was obviously intended to mislead the Company, the Company shall be relieved of all its obligations towards the Insured.

d. immediately inform the Company of every change in his/her address or in his details based on which the insurance was agreed.

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G. OVERLAPPING INSURANCE

If, at the time of submitting a claim, there is also another insurance or compensation scheme which covers the same even or part thereof, the Company will not be liable to pay any amount over the amount that proportionately corresponds to the Company, with the maximum amount being the limit specified for each benefit.

H. NO CLAIM

If no claim is submitted to the Company within six (6) months of the accident or illness, the rights of the Insured or of the Insured's legal representatives to compensation will be barred and the Insured and his/her legal representatives will not be entitled to make any claim against the Company.

EMERGENCY TRAVEL ASSISTANCE BENEFITS

COVERS SCHEDULE	
Emergency Medical Expenses due to Accident or Illness	Up to €10.000
Visit of a member of the insured person's family at the place of hospitalization A. Cost of trip B. Accommodation	100% €100 per day up to 10 days
Financial Guarantee for Legal Actions	Up to € 1000
Extension of the Insured's accommodation due to injury or Illness	€100 per day up to 5 days
Emergency repatriation due to an incident in the country of residence that affects the normal place of residence or business premises of the insured.	100%
Transmission of urgent messages	100%
Transportation and Repatriation of persons accompanying the insured person	100%
Transportation and repatriation of mortal remain	100%
Repatriation or transportation of the insured person after injury or disease	100%

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