

GENERAL INSURANCE TERMS AND CONDITIONS FOR NECESSARY AND URGENT HEALTH CARE INSURANCE FOR FOREIGNERS (VPP/860-15)

Article 1. Introductory provisions

1. The rights and obligations of the Parties to this insurance are governed by the laws of the Czech Republic, in particular the provisions of Act No 326/1999 on the residence of foreign nationals in the Czech Republic, as amended, Act No 89/2012, the Civil Code, as amended, the present Insurance Terms and Conditions, and the arrangements specified in the Insurance Contract and/or contractual arrangements.
2. The Parties are the Policyholder and the Insurer:
MAXIMA pojišťovna, a. s., registered office: Italská 1583/24, Prague 2, 120 00, registration number: 61328464, incorporated by entry in the Commercial Register maintained by the Municipal Court in Prague, Section B, File 3314 (hereinafter referred to as the „Insurer“).
3. The insurance is taken out as insurance covering loss or damage.
4. The insurance applies to all types of stays regulated by law, except for those where a natural person participates compulsorily in public health insurance under special legislation.
5. This insurance meets the conditions set out in Act No 326/1999 on the residence of foreign nationals in the Czech Republic, as amended, for necessary and urgent healthcare.

Article 2. Definitions

1. **Policyholder** means a person who has concluded an insurance contract with the Insurer and is obliged to pay a Premium.
2. **Insured** means a natural person who is not a citizen of the Czech Republic (CR), whose health is covered by the insurance and who resides in the Czech Republic on the basis of a valid and effective permit issued in accordance with the laws of the Czech Republic.
3. **Beneficiary** means the person who, as a result of a Loss Event, has the right to indemnity by demonstrably the incurrance of costs, the reimbursement of which is the subject of indemnity.
4. **Loss Event** means a fortuitous event specified in Article IV of these General Insurance Terms and Conditions (GITC) which is associated with the Insurer's obligation to provide indemnity.
5. **One Loss Event** means a Loss Event under the insurance of one person arising from one cause and includes all facts and their consequences with a causal, temporal or other relationship.
6. **Insured Risk** means any cause of accident, sudden illness or death of the Insured, except for the causes and cases expressly stated in the insurance exclusions.
7. **Sudden Illness** means a sudden and unpredictable deterioration in the health of the Insured which occurs during the validity of the insurance, independently of the will of the Insured, and requires the provision of necessary and urgent health care, including, if necessary, arrangements for the availability thereof.
8. **Necessary Health Care** means a medical examination, diagnosis and treatment of sudden (acute) health conditions, where, from a medical point of view, it is necessary to provide health care immediately or within a very short time.
9. **Urgent Health Care** means a medical examination, diagnosis and treatment of sudden (acute) conditions related to the possibility of impairment of basic vital functions and associated conditions, where, from a medical point of view, delay could cause serious damage to health or threat to the life.

10. **Accident**, for the purposes of this insurance, means the unintentional, sudden and unexpected action of external forces or one's own physical strength, independent of the will of the Insured, which causes damage to the health of, or the death of, the Insured.
11. **Repatriation** means transfer to the country which issued the Insured's travel document or to another country in which the Insured is permitted to reside. It encompasses:
 - (a) repatriation of the sick Insured, if possible from a medical point of view, organised by an assistance company, after approval by the Insurer. In cases where the Insured's state of health requires it, the Insurer may also decide to cover the costs of the necessary medical staff;
 - (b) transport of the remains of the deceased Insured, organised by the assistance company, after approval by the Insurer.
12. **Proof of Health Insurance** means a document issued to the Insured upon entering into an Insurance Contract as proof of the existence and scope of insurance.
13. **Assistance Company** means a third party, specified in the Insurance Contract, which provides assistance services to insured persons to the extent of a call centre under a contract with the Insurer and under the conditions laid down in the Insurance Contract and these GITC. The Assistance Company's contact details are specified in the Insurance Contract and in the Proof of Health Insurance.
14. **Transit** means the transportation of the Insured if all of the following conditions are met:
 - (a) it begins (or ends) in the territory of the Czech Republic and goes to (or from) the state of which the Insured is a national or in which the Insured is permitted to reside;
 - (b) in the case of land transport, this includes direct passage of no more than 24 hours through the territory of other states to or from the state referred to in point (a) (country of Transit);
 - (c) this transportation can be evidenced by a relevant travel document or fuel purchase document.
15. **Schengen Area** means the territory of the countries/signatories of the Schengen Agreement.
16. **Professional Sport** means a sport performed on the basis of a contract with a sports or other organisation or a sport that is the main source of income for a person.

Article 3. Subject of the insurance

1. The subject of the insurance is the reimbursement of the costs of Necessary and Urgent Health Care that the Insured has to undergo in a healthcare facility in the Czech Republic or, if agreed in the Insurance Contract, in the Schengen Area or in Transit countries as a result of an Accident or Sudden Illness occurring over the insurance period during the Insured's stay in the Czech Republic or, if agreed in the Insurance Contract, in the Schengen Area or in the Transit countries. The insurance also covers the reimbursement of the costs of Repatriation of the sick, injured or deceased Insured under the conditions set out in Article 2.
2. If a Loss Event occurs, the Insured is obliged to contact the Insurer's Assistance Company and follow its instructions and the Insurer's instructions.

Article 4. Loss Event and occurrence of loss or damage

1. A Loss Event means the treatment of the Insured in a healthcare facility during the term of the insurance and in the territory covered by this insurance insofar as it concerns Necessary and Urgent Health Care, and/or Repatriation of the Insured under the conditions set out in Article 2(11).

2. The costs of Necessary and Urgent Health Care must be reasonable and necessary, and demonstrably and efficiently incurred in the provision thereof to the Insured in a healthcare facility in the Czech Republic or, if agreed in the Insurance Contract, in a Transit or Schengen Area country, during the insurance period as a result of a Loss Event, as must the costs of necessary Repatriation from the Czech Republic or, if agreed in the Insurance Contract, from the Schengen Area or from a Transit country.
3. As a rule, the Insurer pays these costs directly to the healthcare facility in the Czech Republic that provided the health care on the basis of an invoice issued in accordance with applicable law.
4. Necessary and Urgent Health Care includes:
 - (a) the necessary examination required to establish the diagnosis and treatment;
 - (b) the necessary treatment,
 - (c) necessary hospitalisation of the Insured in a standard-equipped multi-bed room;
 - (d) necessary surgery, including related necessary expenses;
 - (e) purposefully used medical supplies and medicines;
 - (f) from a medical point of view, the necessary transportation of the Insured by the means of medical transport from the place of the Loss Event to the nearest healthcare facility, or transportation of the Insured to the nearest healthcare facility able to provide the Necessary Health Care;
 - (g) the first urgent simple treatment of the Insured's teeth (including, if appropriate, extraction) to eliminate acute pain or to treat the consequences of an Accident.

Article 5. Indemnity

1. The policy limit is determined by the indemnity limit specified in the Insurance Contract.
2. The Insurance Contract includes a partial limit on the costs of Repatriation of the Insured according to Article 2(11).
3. The Insurance Contract also includes the indemnity limit for all Loss Events during the insurance period.
4. The Insurer pays the indemnity in the manner specified in Article 4(3).
5. The Insurer provides indemnity to beneficiaries for treatment in the Czech Republic in the national currency, unless otherwise agreed.
6. If a Loss Event occurs during Transit or during a stay in the Schengen Area, the Policyholder is obliged (except for life-threatening diseases or Accidents) to immediately notify the Insurer's Assistance Company, which will provide the Necessary Health Care and usually pay the cost of this care directly to the provider.
7. If the Insured, without good reason, fails to proceed in accordance with the preceding paragraph and pays for the health care provided to the provider if a Loss Event occurs during Transit or during a stay in the Schengen Area, the Insurer will pay the costs of such Necessary and Urgent Health Care in the amount of reasonable costs of this health care in the Czech Republic. In such a case, the Insurer will pay the compensation in the national currency; the exchange rate used for the translation of the foreign currency will be the mid exchange rate of the relevant currency published by the Czech National Bank as at the date of the Accident or illness.
8. The indemnity is payable within 15 days of the end of the investigation necessary to determine the existence and scope of the Insurer's obligation to pay. The investigation is completed as soon as the Insurer communicates its results to the person asserting the right to indemnity.
9. The Insurer reimburses the costs of Necessary and Urgent Health Care to the healthcare facility, the Insured or another person who has demonstrably incurred these costs in the Czech Republic, to the extent and in an amount corresponding to the coverage of this care out of public health insurance.
10. If the Insured has made direct payment of healthcare costs in the Czech Republic that are intended to be the subject of indemnity, the Insurer may subsequently reimburse reasonable costs of the health care provided to the extent and in an amount corresponding to public health insurance further to the submission of original documents proving the occurrence of a Loss Event, the scope of health care provided, and the amount of payment made.
11. The Insurer's obligation to provide indemnity is subject to the fulfilment of all terms, conditions and obligations arising from these GITC, the Insurance Contract, and related legislation.

Article 6. Exclusions

1. The insurance does not cover loss or damage caused:
 - (a) as a result of a legal factor about which the Insured knew or could have known at the time the Insurance Contract was concluded;
 - (b) by the planned intention to use health care (medical tourism);
 - (c) in connection with activities performed without authorisation;
 - (d) at a time when the Insured is a participant in Czech public health insurance;
 - (e) in a case where the Insured commences Transit in a state of health that could have anticipated illness and the associated Necessary and Urgent Health Care during Transit and this care is provided to the Insured during Transit;
 - (f) in direct connection with an Accident occurring during Professional Sports and training;
 - (g) in direct connection with an Accident occurring while engaging in extreme sports, such as mountaineering, deep diving, speleology, bungee jumping, rafting, adrenaline sports, etc.
2. The Insurer does not provide compensation for loss or damage in the event of:
 - (a) procedures that have not been provided by a healthcare facility or a healthcare professional, or that are not medically recognised;
 - (b) violation of treatment procedures prescribed by a physician;
 - (c) health care to treat such diseases and states of health where health care is appropriate, effective and necessary, but can be postponed and provided upon the Insured's return to his or home country;
 - (d) a situation where the cause or symptoms of the Loss Event occur before the conclusion of the Insurance Contract;
 - (e) treatment related to a disease or Accident or the consequences thereof, which the Insured suffered or knew about during the six months prior to the commencement of insurance, regardless of whether or not the Insured were treated for this;
 - (f) a Loss Event where the cause is or may be related to the pregnancy of the Insured;
 - (g) a situation where the Insured refuses Repatriation, treatment or necessary medical examinations by a physician designated by the Insurer or Assistance Company;
 - (h) a Loss Event caused by war events, rebellion, uprising or other mass violent riots, strikes, lockouts, or terrorist acts, including chemical or biological contamination;
 - (i) illness as a result of the use of medicines or other means without a prescription;
 - (j) examination and treatment of mental disorders, psychological examinations and psychotherapy, treatment of addiction, including examination and complications;
 - (k) venereal diseases (including their complications);
 - (l) AIDS (including its complications) and HIV tests;
 - (m) viral hepatitis C (including its complications).

Article 7. Insurance Contract

1. The Insurance Contract is concluded upon payment of the first premium in the amount specified in the Draft Insurance Contract. The Insurance Contract is effective as of the date specified in the Draft, provided that the first premium is paid by the date specified in the Draft Insurance Contract. If the first premium is not paid by this time, no contract is concluded, the insurance does not arise and the Insurer's Draft lapses.
2. By entering into the Insurance Contract, the Policyholder agrees that the Insurer will allow the Foreign Police remote access to the data on the Insurance Contract in connection with the obligations of the Foreign Police arising from Act No 326/1999 on the residence of foreign nationals in the Czech Republic, as amended. This is without prejudice to the Insurer's obligation to transfer insurance data to the Register of Health Insurance for Foreigners.

Article 8. Insurance period, inception and expiry of insurance

1. The insurance is taken out for the fixed term specified in the Insurance Contract.
2. The insurance is effective from the date specified in the Draft Insurance Contract as the inception date.
3. A condition for the inception and duration of the insurance is that the Insured reside legally in the Czech Republic or, if agreed in the Insurance Contract, in the Schengen Area outside the territory of the Czech Republic, subject to all statutory terms and conditions.
4. The insurance may not be interrupted.

5. The insurance expires under any of the following circumstances:
 - (a) upon expiry of the insurance period specified in the Insurance Contract, such being at midnight on the date agreed as the end of the insurance;
 - (b) upon the death of the Insured;
 - (c) rejection of a visa application by the Department for Asylum and Migration Policy of the Ministry of the Interior of the Czech Republic, termination of the Insured's stay in the territory of the Czech Republic, or the date on which a decision on removal or administrative removal becomes final;
 - (d) the date on which the Insurer receives notification from the Policyholder that, during the term of the insurance, the Insured has become covered by public health insurance in the Czech Republic pursuant to Act No 48/1997 on public health insurance (on the basis of employment in the territory of the Czech Republic or by obtaining permanent residence in the territory of the Czech Republic), together with a copy of a valid public health insurance card of the Czech Republic;
 - (e) written withdrawal by the Policyholder or the Insurer from the insurance contract (as further specified in Article 10);
 - (f) written refusal of insurance benefit by the Insurer pursuant to Section 2809 of the Civil Code;
 - (g) written agreement of the contracting parties;
 - (h) non-payment of the premium after the statutory conditions have been met;
 - (i) written notice of termination by the Insurer or the Policyholder (as further specified in Article 9).

Article 9. Termination of insurance by notice

1. The Policyholder and the Insurer may terminate the insurance by notice within two months of the date of conclusion of the insurance contract. The notice period shall be eight days and shall commence on the day following the date of delivery of the notice to the other contracting party. The insurance shall cease upon expiry of the notice period.
2. The Policyholder and the Insurer may terminate the insurance by notice within three months of the date of delivery to the Insurer of notification that an insured event has occurred. The notice period shall be one month and shall commence on the day following the date of delivery of the notice to the other contracting party. The insurance shall cease upon expiry of the notice period.
3. The Policyholder may terminate the insurance by notice with an eight-day notice period:
 - (a) within two months of the date on which the Policyholder learned that the Insurer had used, in determining the amount of the premium or calculating the insurance benefit, a criterion prohibited under Section 2769 of the Civil Code (breach of the principle of equal treatment);
 - (b) within one month of the date on which the Policyholder was notified of the transfer of the insurance portfolio or part thereof, or of the transformation of the Insurer; or
 - (c) within one month of the date on which notice was published that the Insurer's authorisation to carry on insurance business had been withdrawn.

Article 10. Withdrawal from the insurance contract

1. If the insurance contract has been concluded as a distance contract, the Policyholder shall have the right to withdraw from the contract without giving reasons within fourteen days of the date of its conclusion or of the date on which the insurance terms and conditions were communicated to the Policyholder, if such communication first occurred only at the Policyholder's request after conclusion of the contract.
2. The Policyholder may also withdraw from the insurance contract:
 - (a) if the Insurer breaches its obligation to draw the Policyholder's attention to discrepancies between the insurance offered and the Policyholder's requirements and, when concluding the contract or negotiating an amendment, must have been aware of such discrepancies; or
 - (b) if the Insurer breaches its obligation to answer the Policyholder's written questions truthfully and completely during negotiations on the conclusion or amendment of the insurance contract.

The right of withdrawal shall lapse if the Policyholder fails to exercise it within two months of the date on which the Policyholder discovered, or should have discovered, the breach of the above obligations.

3. The Insurer shall have the right to withdraw from the insurance contract if the Policyholder or the Insured intentionally or negligently breaches the obligation to answer the Insurer's written questions concerning the insurance to be arranged or an amendment to the insurance truthfully and completely, provided that the Insurer proves that, had the questions been answered truthfully and completely, it would not have concluded the insurance contract or the amendment agreement, or would not have arranged certain insurance cover. The Insurer shall also have the right to withdraw from the insurance contract or any part thereof if the Insured refuses to consent to the obtaining of information from healthcare providers or refuses to undergo an examination by a doctor designated by the Insurer.

The right of withdrawal shall lapse if the Insurer fails to exercise it within two months of the date on which the Insurer discovered, or should have discovered, the breach of the above obligations.

4. Withdrawal from the insurance contract shall cancel the contract with effect from its inception.
5. If the Policyholder or the Insurer withdraws from the insurance contract, the contracting parties shall be obliged to settle their mutual obligations. Within one month of the date on which the withdrawal becomes effective, the Insurer shall reimburse the Policyholder for the premium paid, less any insurance benefit already paid. If the insurance benefit paid exceeds the premium paid, the person who received the insurance benefit shall be obliged to reimburse the excess to the Insurer.

Article 11. Premium

1. This premium is a single premium within the meaning of the law, unless otherwise specified.
2. The Insurer is entitled to the premium for the duration of the insurance. The Insurer is entitled to the entire single premium in the event of expiry of the insurance due to a Loss Event.
3. The premium is deemed to have been paid on the date on which it is credited in full to the Insurer's account. The Insurance Contract may stipulate different conditions for the payment of the premium.
4. If the insurance ceases pursuant to Article 8(5)(c) or (g), or by the Policyholder pursuant to subparagraph (i), before the insurance commencement date, the Insurer shall refund to the Policyholder the premium paid, less the costs associated with the establishment and administration of the insurance contract, which amount to 30% of the premium received (cancellation charge).
5. If the insurance ceases pursuant to Article 8(5)(c), (d), (f), (g), or (h), or by the Policyholder pursuant to subparagraph (i), after the insurance commencement date and no insured event has occurred during the term of the insurance, the Insurer shall refund to the Policyholder the unearned premium, less the costs associated with the establishment and administration of the insurance contract, which amount to 30% of the premium received (cancellation charge).

Article 12. Obligations of the Policyholder and the Insured

1. In addition to other, statutory obligations, the Policyholder and the Insured are obliged to:
 - (a) answer truthfully and completely all the Insurer's questions regarding the insurance to be taken out; this also applies to the settlement of a Loss Event;
 - (b) notify the Insurer without undue delay of any changes in facts asked by the Insurer or specified in the Insurance Contract;
 - (c) provide the Insurer with details of all insurance contracts in force at the time of the Loss Event, the subject-matter of which is insurance of the same Insured Risk;
 - (d) do everything possible to prevent a Loss Event and to reduce the extent of the loss or damage;
 - (e) follow the instructions and recommendations of medical staff;
 - (f) undergo the necessary examination or procedure as instructed by a physician;
 - (g) undergo, at the Insurer's request, an examination by a physician designated by the Insurer;
 - (h) comply with regulations on the protection of public health;
 - (i) release a third party (in particular a healthcare facility) from confidentiality about facts related to the Loss Event, should the Insurer so request.
2. If a Loss Event occurs, the Insured must:

- a) oznámit pojistnou událost pojistiteli, a to přímo nebo prostřed(a) notify the Insurer of the Loss Event, directly or through the Assistance Company, which confirms the insurance coverage on behalf of the Insurer for a healthcare facility. In cases where this method is not technically possible due to the severity of the Insured's state of health, it is possible to notify the Loss Event to the Insurer in writing or by email. The notification must be made without undue delay, but no later than five days after the Loss Event;
 - (b) follow the instructions of the Insurer or Assistance Company and undergo a medical examination or treatment in a healthcare facility in the Czech Republic designated by them;
 - (c) in the event of illness or Accident in a Transit or Schengen Area country, if agreed in the Insurance Contract, inform the Assistance Company without undue delay and follow its instructions;
 - (d) notify the law enforcement authorities without undue delay of the occurrence of an event that occurred in circumstances suggesting a crime or misdemeanour;
 - (e) proceed in such a way that the Insurer can exercise the right to compensation for damage caused by the Loss Event and the right to recourse and settlement, and provide the Insurer with cooperation in this context.
3. Persons with reduced legal capacity will be represented by their legal representative or, in the absence of a legal representative, by a person authorised by the legal representative.
 4. If there is a breach of a statutory or contractual obligation, the Insurer has the right to reduce the indemnity depending on how the breach of obligation contributed to the occurrence or amount of damage, unless there is a reduction in insurance coverage under a special law. Otherwise, the Insurer is entitled to subsequently recover the indemnity paid by recourse against the Insured.
 5. The Policyholder is obliged to inform the Insured about the content of the Insurance Contract and the GITC.

Article 13. Obligations of the Insurer

1. In addition to other, statutory obligations, the Insurer is obliged to:
 - (a) answer truthfully and completely all written questions of the Policyholder or the Insured regarding the insurance being taken out or any changes to the insurance that are being discussed;
 - (b) provide indemnity in the event of a Loss Event if all the conditions for its payment are met;
 - (c) initiate, without undue delay, an investigation to determine the scope of its obligation to pay after a Loss Event notification;
 - (d) communicate to the Beneficiary the results of the investigation necessary to determine the indemnity claim and the amount of indemnity;
 - (e) provide the necessary information services to the Insured and healthcare facilities through the Assistance Company, in particular verification of the force and effect of the Insurance Contract, the search for a healthcare facility and the provision of insurance information. Provide, if necessary, a guarantee of the coverage of healthcare costs through the Assistance Company.

Article 14. Passage of rights to the Insurer

1. If the Beneficiary receives indemnity for loss or damage, to the coverage of which the Insured is entitled vis-à-vis a third party, this right will pass to the Insurer up to the amount of indemnity provided by the Insurer.
2. If the Insurer incurs additional costs in connection with the claim due to the fault of the Beneficiary, the Insurer has the right to demand these costs from the Beneficiary.

Article 15. Legal acts and service of documents

1. The Insurance Contract is concluded in writing (electronically or in paper form).
2. The written form is met if the legal act is:
 - (a) recorded in a paper document and signed in the signatory's own hand;
 - (b) made electronically and the signature is replaced by mechanical means;
 - (c) made electronically and electronically signed in accordance with legislation of general application;
 - (d) made electronically and confirmed by the payment of the first premium.

3. Documents relating to the insurance will be served:
 - (a) via a postal licence holder under a special law to the correspondence address of the addressee or, if the correspondence address is not provided, to the last known address of the participant in the insurance;
 - (b) personally by an employee or authorised person of the Insurer;
 - (c) by email, in the form of simple email messages, to the policyholders e-mail address specified in the insurance contract.
4. The documents delivered by the post are deemed to have been delivered on the date of demonstrable receipt of a consignment, upon refusal to accept a consignment, or upon return of a consignment as undeliverable, otherwise on the third working day after being dispatched. If the addressee has not been reached and the Insurer's documents have been deposited with the deliverer, the Insurer's documents are considered delivered on the last day of that deposit period, even if the addressee has not learned about the deposit.
5. If the Policyholder or the Insured changes correspondence address, but does not notify the Insurer of this change in writing and the Insurer's document is returned as undeliverable, the document will be deemed delivered on the date of return to the Insurer, even if the Policyholder or the Insured has not learned of the dispatch thereof.
6. Legal acts or notifications that are made in electronic form are considered delivered on the day following the dispatch thereof to the addressee's email account, except in a situation where it is proven that it is not delivered, for example due to technical problems, in which case the document will be deemed to have been delivered on the 10th day after dispatch thereof.

Article 16. Applicable law and dispute resolution

1. The Insurance Contract and legal consequences arising from it are governed by the laws of the Czech Republic.
2. Disputes arising from the Insurance Contract will be resolved before the courts of the Czech Republic.
3. The Insurer prioritises the out-of-court settlement of any disputes. Complaints may be submitted using the form available at https://www.maximapojistovna.cz/sites/default/files/formular_pro_podani_stiznosti_1.pdf, by email to info@maxima-as.cz or in writing to the Insurer's address. A reply containing notification and justification of the complaint settlement is sent in writing to the complainant within 30 days.
4. A complaint may also be submitted to the Czech National Bank, Na Příkopě 28, Prague 1, which is the oversight authority for the activities of insurance companies. However, the CNB does not have the competence to decide on a dispute between a complainant and the insurer.
5. Further, the Ombudsman may be contacted in matters relating to the right to equal treatment and protection against discrimination. A complaint may be submitted in writing or orally on the record and is not subject to a fee.
6. Disputes between the consumer (Insured or Beneficiary) and the Insurer in the provision of non-life insurance which fall under the jurisdiction of the courts and are not resolved directly with the Insurer may be resolved by the Czech Trade Inspection Authority, Central Inspectorate – ADR Department, Štěpánská 15, 120 00 Prague 2 (for more details, see www.coi.cz). The procedure followed by the Czech Trade Inspection Authority is regulated by Act No 634/1992 on consumer protection, and the rules for the out-of-court settlement of consumer disputes issued on the basis of this act.
7. To resolve consumer disputes, consumers also have recourse to the out-of-court settlement of an insurance dispute by initiating proceedings with the Ombudsman of the Czech Insurance Association. An application is filed electronically using the corresponding form via the platform at <https://www.ombudsmancap.cz>.

Article 17. Final provisions

1. The language of communication is Czech. The Insurance Terms and Conditions are part of the Insurance Contract. If the GITC, the Insurance Contract or other documents that are part of the binding contractual documentation are prepared in more than one language version, the Czech version shall prevail.
2. These GITC are effective as of 1 July 2026.