"APPROVED"
Minutes of the Board of Directors
Insurance Company Basel JSC
Minutes No 09/25 dated April 01, 2025

RULES

VOLUNTARY INSURANCE OF PERSONS TRAVELING ABROAD BASEL INSURANCE COMPANY JSC

Almaty, 2025

CONTENT

1. GENERAL PROVISIONS AND CONCEPTS

1.1. These Rules of Voluntary Insurance of Persons Traveling Abroad (hereinafter referred to as the Rules) regulate the terms and conditions under which Joint-Stock Company Insurance Company Basel (hereinafter referred to as the Insurer) carries out voluntary insurance of persons traveling abroad. The insurance contract for persons traveling abroad is concluded with legal entities (regardless of the form of ownership) and capable individuals (hereinafter referred to as the Insured).

1.2. These Rules have been developed within the class of insurance in case of illness and accident.

1.3. The following terms are used in these Rules:

1) **Insurant –** an adult capable individual, regardless of citizenship, or a legal entity, regardless of residency, who has entered into an Insurance Agreement with the Insurer;
2) **Insured –** a capable individual in respect of whom the Insured enters into the Insurance Agreement;
3) **Beneficiary –** a person who, in accordance with the Insurance Agreement, is the recipient of the insurance payment;
4) **insurance premium –** the amount of money that the Insured is obliged to pay to the Insurer for the latter's obligation to make an insurance payment in accordance with the Insurance Agreement (insurance fee);
5) **insurance amount –** the amount of money for which the insured object is insured and which is the maximum amount of the Insurer's liability in the event of an insured event;
6) **insurance indemnity –** the amount of money paid by the Insurer within the insured amount upon the occurrence of an insured event to compensate for losses caused by the insured event;
7) **Franchise –** the Insurer's exemption from compensation for damage not exceeding a certain amount provided for by the terms of insurance. Franchise can be conditional (non-deductible) and unconditional (deductible). In case of conditional deductible, the Insurer is exempt from compensation for damage not exceeding the established amount of deductible, but must compensate for damage in full if its amount exceeds this amount. The franchise is set either as a percentage of the insured amount or in absolute amount. Established by insurance programs (internal document of the company)
8) **insured event –** an event upon the occurrence of which the Insurance Agreement provides for the insurance payment;
9) **service company / Assistance / representative of the Insurer** – a legal entity that, on the basis of the Cooperation Agreement with the Insurer, provides services for the organization and provision of medical and other services, in accordance with the insurance program chosen by the Insured in the country of temporary residence;
10) **Insurance Policy** – a document issued by the Insurer to the Insured in case of conclusion of the Insurance Agreement by the Insured's accession to these Rules. The terms of the Insurance Agreement and the Insurance Policy used in these Rules shall have equivalent use and shall regulate the relationship between the Insurer and the Insured (the Insured, the Beneficiary), the amount, procedure and terms of payment of the insurance premium, the amounts, procedure, amounts and terms of insurance payments, as well as other insurance conditions;
11) **sudden illness** – an acute and unexpected health disorder of the Insured, characterized by the occurrence of various forms of impairment of body functions, injuries, including injuries that occurred during the period of insurance coverage, requiring urgent

medical intervention in order to prevent further harm to the health or threat to the life of the Insured;

12) **medical provider** – a legal entity or an individual licensed to provide medical care, with whom the Insurer's service company has entered into an Agreement for the provision of paid services to the Insured;
13) **Hospital** is a medical and preventive institution that:
    - provides care and treatment for the sick or wounded;
    - has diagnostic, surgical and other departments;
    - provides 24-hour care by certified nurses;
    - supervised by one or more doctors.
    - operates within the framework of state licenses
14) **The following is not considered a hospital:**
    - maternity hospitals, departments for patients undergoing rehabilitation after planned surgical interventions and treatment of chronic diseases, geriatrics department;
    - sanatoriums, rest homes, nursing homes.
15) **disease** – a violation of the normal vital functions of the Insured's body due to functional and/or morphological changes;
16) **medical services are** services related to the provision of qualified medical care;
17) **Medicines are a** substance or a mixture of substances of synthetic or natural origin in the form of a dosage form (tablets, capsules, solutions, ointments, vaccines, etc.) used for the diagnosis and treatment of diseases, prescribed by a doctor.
18) **insurance territory** – the territory to which the insurance coverage under the Insurance Agreement applies;
19) **trip** – departure from the borders of the Republic of Kazakhstan for the purpose of recreation, study, working visit, tourism, participation in competitions, etc.;
20) **relatives** – spouse, parents, children, adoptive parents, adopted, full and half-siblings, grandfather, grandmother, grandchildren;
21) **doctor** – a medical worker who has a certificate of a specialist in the field of medicine, as well as a license to carry out a certain type of medical activity;
22) **sport** – complexes of physical exercises for the development and strengthening of the body, competitions in such exercises and complexes, as well as the system of organization and conduct of these competitions;
23) **medical evacuation** – transportation of the Insured from abroad (from the territory of insurance), which also involves the cost of an accompanying person (if such escort is prescribed by a doctor) to the checkpoint of the nearest airport of the Republic of Kazakhstan.
24) **Insurer's expenses** – unavoidable, necessary costs arising outside the country of permanent residence/citizenship of the Insured, arising in connection with the diagnosis of a condition (disease), therapeutic or surgical treatment provided or prescribed by a qualified practitioner, which cannot be postponed until the return of the Insured to the country of his/her permanent residence/citizenship, purchase of medicines, provision of dental care, return of the body of the deceased Insured to the country of permanent residence, return of the injured Insured accompanied by a medical worker, assistance in finding and returning lost luggage, expenses for the return of Insured children under 16 years of age in case of hospitalization or death of an adult Insured;
25) **posthumous repatriation** – transportation of the remains of the Insured in the event of his death from the country of temporary stay to the international airport of the country

of permanent residence. At the same time, the Insurer shall not bear the costs of funeral services, burial, as well as transportation of the body within the country of permanent residence. Expenses related to the repatriation of the body (remains) of the Insured:

- legal registration and expenses for the autopsy of the body, the coffin required for international transportation;
- transportation of the body (remains) to the international airport of the country of permanent residence of the Insured.

26) **Insurance Program –** a list of covered expenses in the event of an insured event. The Insurance Program provides the Insured with a choice of a certain list of medical and service services broken down by insurance territories, insured amounts and insurance periods.
27) **civil war** is an armed confrontation between two or more parties related to the same country, but belonging to different ethnic, religious or ideological groups. The definition includes: armed uprising, revolution, anti-government agitation, riot, coup d'état, consequences of martial law.
28) **Accident** is a sudden, short-term event (incident) that occurred against the will of a person as a result of external mechanical, electrical, chemical or thermal impact on the Insured's body, resulting in harm to health, injury or death.
29) **bodily injuries** – violation of the physical integrity of the Insured's body, which occurred during the period of insurance coverage as a result of an accident.
30) **Carrier** is a legal entity/individual engaged in the transportation of passengers by air, rail, sea, road transport, which has a license for this type of activity and performs them according to a regular schedule.
31) **prescription** - a written doctor's prescription for the Insured on the list, dosage and procedure for taking medicines.
32) **Emergency medical care is the** provision of medical services in the event of life-threatening conditions, as well as conditions requiring immediate medical intervention.
33) **country of temporary stay** – the country specified in the Insurance Agreement and included in the insurance territory, except for the country whose citizenship the Insured has and (or) permanently resides there.
34) **evacuation of Insured children under 16 years of age in case of hospitalization or death of an adult Insured** – organization by the Assistance of departure of children to the Republic of Kazakhstan, in case of hospitalization or death of an adult Insured in the territory of insurance during the period of validity of insurance coverage.
35) **Database formation and maintenance organization** – a non-profit organization with state participation, which forms and maintains a database on compulsory voluntary types of civil liability insurance on the basis of the Law of the Republic of Kazakhstan "On Insurance Activities and Legislative Acts of the Republic of Kazakhstan on Compulsory Types of Insurance".

2. OBJECT OF INSURANCE

2.1. The object of insurance under these Rules is the property interests of the Insured (Insured) related to the expenses of the Insured (Insured, Beneficiary) for medical and service services in accordance with the Insurance Agreement and the insurance program chosen by the Insured, which arose as a result of an acute sudden illness or accident during his stay in the insurance territory specified in the Insurance Agreement.

3. INSURANCE ENTITIES

3.1. Insurants may be capable adult citizens of the Republic of Kazakhstan, foreign citizens permanently residing in the territory of the Republic of Kazakhstan, as well as persons with a residence permit in the Republic of Kazakhstan and legal entities of any organizational and legal form.

3.2. The Insured, if he is an individual, may be the Insured at the same time, taking into account the requirements of subpara. 3.4. – 3.5., and it shall be indicated in the Insured column. If he is not indicated in the list of the Insured, the Insured remains only the Insured.

3.3. The Insured may designate another person as the Insured in the Insurance Agreement. The Insurance Agreement may be concluded both in favor of one Insured (individual contract) and in favor of several Insured (collective agreement).

3.4. Citizens of the Republic of Kazakhstan, foreign citizens permanently residing in the territory of the Republic of Kazakhstan, as well as persons who have a residence permit in the Republic of Kazakhstan can be insured.

3.5. Individuals over 90 years of age, persons leaving for permanent residence outside the Republic of Kazakhstan for the purpose of planned treatment or rehabilitation are not accepted for insurance. Insurance payment is not made to such persons.

4. DEFINITION OF CONCEPTS AND MEDICAL INDICATIONS

4.1 Medical indications are objective reasons and conditions for receiving medical services and/or medicines for the diagnosis and treatment of a sudden illness that caused the Insured's application, in accordance with his insurance program.

4.2 Medical services and medicines are considered prescribed in accordance with Medical Indications if these medical services and medicines are generally recognized in the medical community, necessary and sufficient for the diagnosis and treatment of the Insured's disease.

4.3 Medical services and medicines are not considered prescribed in accordance with Medical Indications if these medical services and medicines were not prescribed for the diagnosis and treatment of a particular Insured in order to provide assistance in case of sudden deterioration of health or injury.

4.4 When organizing inpatient treatment for emergency indications, the choice of a medical institution is made by an employee of the Assistance Company or the Insurer.

4.5 In the course of inpatient treatment for emergency indications, the Insurer covers diagnostics and treatment related only to the cause of hospitalization (main disease) of the Insured.

5. INSURED EVENT. LIST OF INSURED EVENTS

5.1. An insured event is a sudden, unforeseen and unintentional illness and/or accident that occurred during the period of validity of the insurance cover and in the territory of insurance, and as a result of which harm was caused to the life and/or health of the Insured, resulting in the occurrence of:

1) emergency medical care, including visits and consultations of doctors, medical examinations;
2) expenses for medicines prescribed by a doctor - according to the limit established by the insurance program;
3) expenses for the organization and provision of emergency inpatient care;
4) expenses for dental care, according to the limit established by the insurance program - acute toothache resulting from acute inflammation of the tooth

and/or surrounding tissues of the oral cavity, or dentofacial injury received as a result of an accident;

5) expenses related to the provision of medical and transport assistance, namely medical transportation of the Insured by ambulance from the scene of the accident / occurrence of an insured event to the hospital in the territory of insurance;
6) expenses for medical evacuation of the Insured to the Republic of Kazakhstan organized by Assistance, if:
   - the costs of staying in the hospital may exceed the limit established by the Insurance Agreement, provided that the Insured refuses to pay the difference between the cost of the estimated medical expenses and the amount of the limit established by the Insurance Agreement;
   - it is not possible to provide the Insured with the required medical care in the country of temporary residence. Medical evacuation is carried out only in cases where its necessity is confirmed by the conclusion of the Insurer's doctor on the basis of documents of the local attending physician and in the absence of medical contraindications;
   - Long-term treatment is required due to hospitalization (more than 2 (two) weeks).
7) the costs of repatriation of the body of the deceased Insured are covered in the amount of the actual cost of transporting the body by the air carrier to the international port of the country of permanent residence within the insured amount under the Insured's program, namely:
   - legal registration of documents and expenses for the autopsy of the body, the coffin required for international transportation;
   - transportation of the body (remains) to the international airport of the country of permanent residence of the Insured.
8) expenses for the return of Insured children under 16 years of age to the Republic of Kazakhstan, in case of hospitalization or death of an adult Insured, namely the cost of a flight organized by Assistance;
9) expenses related to the organization of assistance in the search and return of lost baggage;
10) expenses for the organization and provision of inpatient treatment for the first time diagnosed symptomatic disease of coronavirus infection Covid 19 during the period of insurance coverage. The disease is considered symptomatic in the presence of complaints and clinical manifestations of viral infection in accordance with the treatment protocol of the host country.

5.2 **List of conditions and diseases covered by the Insurer**:

1) unconsciousness;
2) external bleeding accompanied by pronounced blood loss;
3) internal bleeding and hemorrhages in organs;
4) burns and frostbite;
5) violation of the anatomical integrity of the body;
6) insect bites, animal bites;
7) chemical burns and poisoning as a result of an accident;
8) food poisoning;
9) allergic reactions (angioedema, Lyell's syndrome, Stevenson-Jones syndrome);
10) convulsions of unknown origin with loss of consciousness;
11) acute surgical diseases;
12) acute renal failure;

13) acute liver failure;
14) acute cerebral disorders (strokes);
15) acute respiratory failure;
16) acute cardiovascular failure (heart attacks);
17) hypertensive crises;
18) shock of any etiology.

5.3. The insurance contract may provide for a different list of insured events.

6. EXCLUSIONS FROM INSURED EVENTS AND LIMITATION OF INSURANCE. GROUNDS FOR EXEMPTION OF THE INSURER FROM INSURANCE PAYMENT

6.1 Insured events, according to these Rules, are not recognized as expenses of the Insured, as a result of:

1) war, invasion, hostile actions of a foreign state, military or similar operations (whether war is declared or not) or civil war;
2) popular disturbances of any kind, mass riots or strikes, riots, lockouts, civil disorders that acquire dimensions or grow to the size of a popular uprising, riot, civil unrest, military mutiny, revolution, military seizure or usurpation of power, confiscation, requisition or nationalization of property, terrorist acts;
3) the effects of a nuclear explosion, radiation or radioactive contamination;
4) natural disasters, earthquakes, floods, mudflows, hurricanes;
5) man-made disasters, explosions and leaks of toxic substances at factories, breakthroughs in pipelines or accidents, disasters, train wrecks, shipwrecks, etc.;
6) deliberate actions of the Insured (Insured, Beneficiary) aimed at the occurrence of an insured event or contributing to its occurrence, except for actions committed in a state of necessary defense and extreme necessity;
7) actions of the Insured (Insured, Beneficiary) recognized in accordance with the procedure established by legislative acts as intentional crimes or administrative offenses that are in a causal relationship with the insured event;
8) risks not provided for by the insurance program;
9) if the purpose of the trip specified by the Insured in the Insurance Agreement does not correspond to the actual purpose of the Insured's trip;
10) evacuation/repatriation of the Insured at his own request/discretion or on the basis of a doctor's order, but organized independently by the Insured (Insured, Beneficiary) or any other persons without the participation of the Assistance and/or written consent with the Insurer;
11) independent organization of the return of children of the deceased adult Insured, close relatives or any other persons without the participation of the Assistance and/or written agreement with the Insurer.

6.2 Insurance restrictions apply to persons over 90 years of age.

6.3 **The grounds for refusal of the Insurer to make the insurance payment may also be the following**:

1) communication by the Insured to the Insurer of knowingly false information about the object of insurance, insurance risk, insured event and its consequences;
2) deliberate failure by the Insured to take measures to mitigate losses from the insured event;
3) receipt by the Insured of the appropriate compensation for loss on property insurance from the person guilty of causing the loss;

4) obstruction by the Insured to the Insurer in the investigation of the circumstances of the occurrence of the insured event and in establishing the amount of the loss caused by him;
5) failure to notify or untimely notification of the Insurer about the occurrence of an insured event;
6) actions of the Insured (Beneficiary) committed in a state of alcoholic, toxic or narcotic intoxication, or under the influence of potent drugs or psychotropic substances;
7) waiver of the Insured's right of claim to the person responsible for the occurrence of the insured event, as well as transfer to the Insurer the documents necessary for the transfer of the right of claim to the Insurer. If the insurance indemnity has already been paid, the Insurer has the right to demand its return in full or in part;
8) other cases provided for by these Rules and the Insurance Agreement.

6.4 **The insurer does not make an insurance payment for:**

1) indirect commercial losses of the Insured (Insured, Beneficiary), losses (fines, penalties, penalties), losses in the form of lost profits;
2) moral damage;
3) provision of the Insured in the hospital with conditions of increased comfort - a separate room and a suite, telephone, TV, air conditioning, hairdresser, masseur, cosmetologist, interpreter services, service in the ward, stay of an accompanying person (except for cases of staying in the ward with a child under 3 years old);
4) expenses for the provision of emergency medical care to the Insured related to the commission or attempt to commit an unlawful act that entailed, in accordance with the current legislation of the country of temporary residence, an administrative penalty or criminal prosecution against the Insured, except in cases of exceeding the limits of necessary defense;
5) legal costs;
6) any travel expenses of the Insured for a trip from a medical institution to the place of temporary residence in the territory of insurance, except for a trip by ambulance.

6.5 **The insurer does not make an insurance payment in the following cases:**

1) provision of medical services that are not emergency medical care and are not prescribed by the attending physician in case of emergency;
2) chronic diseases and their consequences, complications, as well as exacerbations, with the exception of conditions that directly threaten the life of the Insured, except for cases when the exacerbation/complication of chronic diseases was the result of an injury or other event recognized as an insured event. If the Insured disputes the diagnosis established by the doctor who provided medical care in the country of temporary residence, then he/she is obliged to undergo a medical examination in the territory of the Republic of Kazakhstan at the direction of the Insurer;
3) oncological diseases (benign and malignant), their complications and exacerbations, as well as their diagnosis, regardless of the timing of detection;
4) diseases that required treatment during the last 6 months before the start of the Insurance Agreement, as well as diseases that the Insured had on the day of the start of the trip, consequences (complications) that arose in the period after surgical or therapeutic treatment of this disease;
5) the state of incomplete recovery of the Insured or being in the process of treatment before going abroad, including the condition after surgery;
6) preventive vaccinations and medical examinations;

7) mental illness, depression, psychological services;
8) selection and purchase of medical corrective equipment: glasses, contact lenses, hearing aids, related medical products: wheelchairs, bandages and crutches, prostheses, etc.;
9) cosmetic, plastic and reconstructive surgery of any kind, except for the event that led to the violation of the anatomical integrity of the body as a result of an event recognized as an insured event, when skin grafting or restoration of vascular functions (burns) is necessary;
10) effects of solar radiation, treatment of sunburn;
11) HIV infection, AIDS, sexually transmitted diseases (STDs), urogenital infections, including their diagnosis and examination;
12) treatment in sanatoriums, hospitals, rest homes and other organizations of medical or sanatorium-resort type, guardianship care;
13) the state of pregnancy, childbirth, any complications of pregnancy, as well as abortions, including spontaneous abortions, with the exception of miscarriages up to 12 weeks;
14) all kinds of prosthetics, implantation, including eye and dental;
15) infectious diseases that could have been prevented by advance vaccination and (or) resulting from violation of preventive quarantine measures by the Insured after contact with a carrier;
16) examinations, tests, intake of medicines that go beyond the limits of necessity and sufficiency, in the opinion of the doctors of the service company (representative of the Insurer);
17) costs associated with the provision of services that are not medically essential;
18) dental treatment of teeth (replacement of fillings, cosmetology, whitening, prosthetics, veneers), except for emergency care for acute toothache;
19) suicide or attempted suicide, any harm to one's own health by the Insured;
20) intentional infliction of harm to their health by the Insured in order to receive an insurance payment for medical services received in the territory of insurance;
21) artificial insemination, infertility treatment or prevention of conception;
22) driving a vehicle by a person who does not have a license, or a person who is intoxicated or under the influence of drugs, psychotropic substances and desensitizing (sedative) substances that cause drowsiness, disorientation, impaired concentration;
23) self-treatment, prescription and treatment by a relative of the Insured;
24) diseases, if they are caused by the actions of a doctor not authorized by the Insurer;
25) voluntary refusal of the Insured to comply with the doctor's prescriptions received by him/her in connection with the application for the insured event, and all the consequences of such refusal;
26) treatment and diagnostics by the following methods: iridology, auriculodiagnostics, light diagnostics, dry and underwater extracts, fluting baths, ultraviolet irradiation (UV) of blood, autohemotherapy, vacuum therapy, manual therapy, herbal medicine, treatment in a hyperbaric chamber, occupational therapy, Voll study, infrasound therapy (IFS), bioresonance therapy, acupuncture, water procedures; balneology: mud therapy, etc.;
27) medical and/or other expenses are incurred by the Insured after the expiration of the Agreement, even if the insured event occurred during the validity of the Insurance Agreement.

6.6 The Insured's expenses as a result of engaging in any professional or amateur sports, active recreation, participation in events/entertainment with elements of sports, hang gliding, parachuting, aviation sports/entertainment, mountaineering/climbing, speleology, scuba diving with the use of breathing apparatus, skiing/entertainment, surfing, hunting, horseback riding are not an insured event and are not subject to reimbursement riding, riding a bicycle, motorcycle, moped and/or scooter (jet ski);)

6.7 The expenses of the Insured as a result of active recreation, professional sports are not an insured event and are not subject to reimbursement. This exclusion does not apply to a program that covers these risks.

6.8 In accordance with the terms of these Rules, events related to the Insured's application to a service company/Assistance for services due to:

1) diseases and their consequences that arose before the beginning of the insurance period or the end of the insurance period;
2) if at the time of conclusion of the Insurance Agreement, the Insured is already hospitalized or is in the territory of insurance;
3) any chronic diseases and their consequences and complications, with the exception of sudden exacerbations that directly threaten the life of the Insured;
4) alcoholism, drug addiction, substance abuse, taking psychotropic drugs;
5) parasitic and infectious diseases (helminthiasis): ascariasis, giardiasis, hookworm, opisthorchiasis, cestodiasis;
6) benign neoplasms (adenoma, fibroids, mastopathy, etc.) and hyperplastic processes (cervical erosion, endometriosis, etc.);
7) congenital diseases (including malformations and developmental anomalies);
8) skin diseases (psoriasis, eczema, all types of lichens, mycoses, alopecia, vitiligo, scabies, etc.);
9) cytomegalovirus and herpes infections, fungal diseases;
10) Crohn's disease, hepatitis, cirrhosis of the liver, ulcerative colitis, dysbacteriosis, celiac disease, ulcer of the 12th denum and stomach;
11) diagnosis and treatment of posture disorders: scoliosis, kyphosis, lordosis, flat feet;
12) vascular disease (obliterating endarteritis, atherosclerosis, aneurysm, varicose veins, thrombophlebitis; Takayasu's disease (nonspecific aortoarteritis), Buerger's disease (thromboangiitis obliterans), varicocele, rectal varices - hemorrhoids;
13) Eye diseases: myopia, astigmatism, cataracts, glaucoma, retinopathy, spasm of accommodation, long-term consequences of eye injury in the form of retinal detachment, eyelid massage and eyeball biostimulation services. Costs associated with surgical vision correction, including the use of laser, manipulations associated with the use of hardware and software systems in ophthalmology;
14) surgeries, cosmetic treatment and other types of treatment related to the elimination of appearance defects or bodily anomalies, sex reassignment surgery, weight correction, etc.
15) diagnosis and treatment of nutritional disorders and metabolic disorders: obesity, uric acid diathesis, gout, dystrophy, etc.;
16) diagnosis and treatment of endocrine diseases: diabetes mellitus, thyroid diseases and their consequences;
17) systemic diseases (SLE, periarteritis nodosa, systemic scleroderma, ankylosing spondylitis, Sjögren's disease, Reiter's disease, DOA, dermatomyositis, systemic vasculitis, rheumatism, etc.), diseases of the skeletal system (osteoporosis, heel spurs, dysplasia, etc.), autoimmune diseases (AIT (goiter), AIH (hepatitis), AI blood disease, etc.);
18) diagnosis and treatment of prostatitis;

19) diagnosis and treatment of infertility, menstrual disorders, impotence, all methods of contraception, any complications of pregnancy over 12 weeks;
20) transplantation or prosthetic surgeries, including endoprosthetics, reconstructive surgeries, organ transplantation operations, as well as the consequences of such operations;
21) medical expenses associated with coronary angiography, MRI/CT, expensive and complex types of diagnostics without the consent of the Insurer's representative; as well as surgical interventions on the heart (coronary artery bypass grafting, stenting, installation of an artificial pacemaker, etc.);
22) diagnosis and treatment of visible hereditary pathology (dwarfism, accelerated puberty), hereditary, gene, chromosomal diseases and congenital and acquired malformations, cerebral palsy;
23) diagnosis and treatment of allergic chronic diseases, with the exception of acute conditions requiring urgent measures;
24) therapeutic methods used in the period of remission of respiratory allergoses (for example, specific hyposensitization, histamine therapy and methods of vegetative therapy);
25) treatment with hemodialysis, plasmophoresis and hemosorption, ultraviolet blood ultraviolet radiation, hyperbaric chamber, intestinal irrigation;
26) treatment of diseases of the heart, blood vessels, nervous system that require surgical intervention, including the installation of an artificial pacemaker;
27) hepatocerebral dystrophy (Wilson-Konovalov disease), Alzheimer's disease, Parkinson's syndrome, epilepsy, cerebral palsy, post-traumatic encephalopathy;
28) non-traditional methods of diagnosis and treatment: homeopathy, hirudotherapy, manual therapy, reflexology, phytotherapy and treatment with natural remedies;
29) occupational diseases – diseases that have arisen as a result of the impact of adverse factors of the working environment on the body;
30) acute and chronic radiation sickness;
31) chronic hepatitis of any etiology and degree of activity;
32) medical examination carried out for the purpose of issuing certificates for permission to carry weapons, obtaining a driver's license, visiting health institutions, admission to educational institutions, issuing certificates for traveling abroad, unless otherwise provided for by the insurance program;
33) non-compliance by the Insured with the legislation of the country of temporary residence when carrying out any activities;
34) carrying out by the Insured in the country of temporary residence of activities for which special permits are required;
35) purchase of medical devices (masks, inhalers, thermometers, bandages, cotton wool, adhesive plaster, enemas, chairs, crutches, glasses, dental and ear prostheses, etc.);
36) treatment of SARS, bird flu;
37) expenses related to Covid-19 tests without symptoms of the disease, unless it is provided for by the Insurance Agreement, insurance program;
38) determination of the level of blood hormones.

6.9 The purchase of the following medicines is not included in the insurance coverage (is not an insured event):
1) contraceptives;
2) vitamins (except vitamins for intravenous and intramuscular use);
3) anti-tuberculosis drugs;

4) dietary supplements;
5) homeopathic medicines;
6) anorexants;
7) cosmetics;
8) biological stimulants (for example, ginseng tincture, etc.);
9) enzymes (other than digestive enzymes);
10) antidepressants, nootropics.

6.10 If during the term of the Insurance Agreement it turns out that the Insurance Agreement is concluded in relation to one of the specified in clause 3.5. of these Rules of Persons, then in respect of such Insured, the insurance coverage shall be terminated from the moment of conclusion of the Insurance Agreement.

7. PROCEDURE FOR DETERMINING THE INSURED AMOUNT. FRANCHISE

7.1. The sum insured is the amount of money specified in the Insurance Agreement, within which the Insurer is responsible for the fulfillment of its obligations under the Insurance Agreement. The sum insured is the maximum amount of the Insurer's liability: in any case, the maximum amount of the insurance indemnity (maximum amount of liability) for each insured event does not exceed the sum insured specified in the Insurance Agreement.

7.2. The sum insured is established by agreement of the parties, based on the number of Insured Persons selected by the Insured, the insurance program and territory specified in the Insurance Agreement. The sum insured cannot be changed after the start of the insurance period. Depending on the Program selected by the Insured, sublimits on the types of coverage shall also apply in accordance with these Insurance Rules.

7.3. The Insurance Agreement may provide for a franchise. The franchise is set either as a percentage of the insured amount or in absolute amount.

7.4. The type and amount of the franchise shall be established by agreement between the Insured and the Insurer and shall be specified in the Insurance Agreement.

7.5. A deductible can be established for one insured event or for each insured risk. If there were several insured events or risks, the amount of the franchise is taken into account when calculating the amount of damage for each of them.

8. PROCEDURE FOR DETERMINING THE INSURANCE PREMIUM

8.1. The amount of the insurance premium payable under the Insurance Agreement is calculated according to the tariffs established by the Insurer's internal documents.

8.2. The insurance premium is payable in cash or non-cash form:
1) for individuals - by a one-time payment;
2) for legal entities - by a lump sum, if the insurance coverage period is up to 6 months, unless otherwise provided by the Insurance Agreement.

8.3. If the insurance premium or the first insurance premium is not paid on time, the Insurer has the right to terminate the Agreement early from the date of non-payment of the insurance premium. In this case, a written notification of the Insurer to the Insured is not required.

8.4. If by the time of the insured event the insurance premium (first insurance installment) is still not paid, the Insurer:
- is exempt from fulfilling its obligations under the Agreement and is not responsible for insured events that occurred during the specified period, or

- has the right to set off the amount of unpaid insurance premium (insurance premium) when determining the amount of insurance payment.

8.5. In case of non-payment of the insurance premium (regular insurance premium) in full before the period specified in the Insurance Agreement, the Insurer has the right to:

1) unilaterally terminate the insurance coverage under the Insurance Agreement from the day following the day of the overdue date for payment of the next insurance premium. At the same time, the Insurer shall not be liable for insured events that occurred before the date of non-payment of the insurance premium (next insurance premium);
2) in the event of an insured event, make an insurance payment to the Service Company in full (at the same time, the Insurer has the right to demand from the Insured a refund of the amount of payment, including in court);

8.6. The Insurer has the right to demand payment of a penalty for untimely fulfillment of monetary obligations by the Insured in accordance with Article 353 of the Civil Code of the Republic of Kazakhstan.

9. PROCEDURE FOR CONCLUDING AN INSURANCE CONTRACT.

9.1. The Insurance Agreement shall be concluded:

1) in writing by drawing up the Insurance Agreement by the parties. Insurance Contracts may provide for the amendment, exclusion of certain provisions of the Insurance Rules, as well as additional conditions determined at the conclusion of the Insurance Agreement, which must be expressly stated in the Agreement.
2) in writing or electronically by the Insured's accession to these Rules and issuance of an insurance policy by the Insurer to the Insured. The forms of the Insurance Agreement and the Insurance Policy shall be approved by the Insurer's internal documents.

9.2. To conclude the Insurance Agreement, the Insured shall provide the Insurer with an application form signed by the Insurer in the form established by the Insurer, in which the Insured is obliged to indicate accurate and complete information in accordance with the details of the application form. The insurance application form is an integral part of the Insurance Agreement. The format of the form is approved by the Insurer's internal documents.

9.3. If the Insurant indicates knowingly false information in the application, the Insurer shall have the right to invalidate the Insurance Agreement in the manner prescribed by the legislation of the Republic of Kazakhstan upon occurrence of an insured event. The Insurer may not demand that the Insurance Agreement be declared invalid if the circumstances about which the Insured has been silent have already disappeared.

9.4. Upon conclusion of the Insurance Agreement, the Insured shall inform the Insurer in writing in the application form of the circumstances known to the Insured, which are essential for determining the probability of occurrence of the insured event and the amount of possible losses from its occurrence (insurance risk).

9.5. These Insurance Rules are a public document and are provided upon request, the fact of familiarization with them is certified by the Insured in the Insurance Application Form.

9.6. The insurance contract must contain:

1) surname, first name, patronymic (if it is indicated in the identity document) and place of residence of the Insured (if it is an individual) or its name, location and bank details (if it is a legal entity);
2) surname, first name, patronymic (if it is indicated in the identity document), contact phone number and individual identification number of the insurance

agent (if it is an individual resident of the Republic of Kazakhstan) or name, location, contact phone number and business identification number of the insurance agent (if it is a legal entity resident of the Republic of Kazakhstan);

3) an indication of the presence or absence of a commission fee due to the insurance agent;
4) indication of the object of insurance;
5) indication of the insured event and the conditions of its occurrence;
6) the amount of the insurance amount, the procedure and terms for making the insurance payment;
7) the amount of the insurance premium, the procedure and terms of payment of the insurance premium;
8) date of conclusion and term of the Insurance Agreement;
9) instructions on the Insured and the Beneficiary;
10) number, series of the Insurance Agreement;
11) cases and procedure for making changes in the terms of the Insurance Agreement;
12) the Insurant's obligation to immediately inform the Insurer of significant changes in the circumstances reported to the Insurer at the conclusion of the Agreement, if these changes may significantly affect the increase in the insurance risk during the validity period of the Insurance Agreement;
13) terms of notification of the Insured (Insured, Beneficiary) about the missing documents necessary for making the insurance payment;
14) type of currency of the insured amount, insurance payment and insurance premium;
15) indication of the identification number, sign of residency and sector of the Insured's economy;
16) indication of the identification number, sign of residence and sector of the economy of the Insured (Beneficiary), if he is not the Insured under the Insurance Agreement, if the Insured (Beneficiary) is indicated in the Insurance Agreement;
17) indication of the territory of validity of the Insurance Agreement;
18) rights, obligations and responsibilities of the parties;
19) signatures of the parties.

9.7. By agreement of the parties, other terms and conditions may be included in the Insurance Agreement.

9.8. The Insured (Insured, Beneficiary) shall be prohibited from transferring the Insurance Agreement to other persons for the purpose of receiving services under the Insurance Agreement. If it is established that the Insured (Insured, Beneficiary) has transferred the Insurance Agreement to another person for such purpose, the Insurer shall have the right to terminate the Insurance Agreement early.

9.9. In case of loss of the Insurance Agreement, the Insured (Insured) shall immediately notify the Insurer thereof in writing. Lost documents are invalid from the date of receipt by the Insurer of a written notice from the Insured (Insured) and cannot be the basis for applying to the Assistance Company. The Insurer shall issue a duplicate of the Insurance Agreement on the basis of the Insured's written application.

9.10. The Insurer shall be released from liability for making insurance payment to another person under the lost Insurance Agreement, in case of failure to notify or untimely notification of the Insurer by the Insured, the Insured about the loss of the Insurance Agreement.

9.11. In case of changes in the information specified in the Insurance Agreement, the Insurance Agreement shall be terminated, in connection with which a new Insurance Agreement shall be concluded, which shall include new information.

10. TERM AND PLACE OF VALIDITY OF THE INSURANCE CONTRACT

10.1. The Insurance Agreement is concluded for one specific trip (trip, hike, excursion, business trip, training, etc.) of the Insured to the country of temporary residence for the period of its duration, except for multiple trips of the Insured during a certain period. If the Insured travels to several countries at once, Insurance Contracts are issued for different insurance territories, taking into account different periods of stay in these territories.

10.2. If the Insurance Agreement provides for multiple (two or more times during the term of the Insurance Agreement) trips of the Insured abroad, then it is concluded for a certain period (no more than one calendar year) and the insurance coverage is valid during the period of the Insured's actual stay in the territory of insurance.

10.3. The actual number of days during which the Insurance Agreement is valid shall be specified in the Insurance Agreement.

10.4. The validity of the insurance cover begins from the moment the Insured crosses the border of the state specified in the Insurance Agreement (entry into the territory of insurance is confirmed by a mark of the border services in the passport), but not earlier than the beginning of the insurance period specified in the Insurance Agreement, and no later than the day following the day of crossing the border by the Insured and terminates:

1) at the time of crossing the border of the country of temporary stay (country of rest) by the Insured (departure from the territory of insurance);
2) at 24.00 on the day specified in the Insurance Agreement as the last day of the insurance coverage, regardless of the place of stay of the Insured.

10.5. In accordance with these Rules, the Insurance Agreement shall apply exclusively to the territory specified in the Insurance Agreement.

11. RIGHTS AND OBLIGATIONS OF THE PARTIES

11.1. **The Insurant has the right to:**

1) to require information from the Insurer on its solvency and financial stability;
2) obtain a duplicate of the Insurance Agreement in case of its loss;
3) to demand the provision of services to the Insured in accordance with the selected insurance program. In case of failure to provide such services, the Insured must immediately inform the Insurer about it;
4) terminate the Insurance Agreement early in accordance with the procedure established by these Rules;
5) receive an insurance payment in the event of an insured event, if he is a Beneficiary under the Insurance Agreement;
6) perform other actions provided for by the Insurance Agreement and the legislation of the Republic of Kazakhstan.

11.2. **The insurant is obliged to:**

1) when entering into the Insurance Agreement , inform the Insurer of all circumstances known to it that are essential for the assessment of the insurance risk and the Insurer's decision to enter into the Insurance Agreement;
2) pay insurance premiums in the amount, procedure and terms established by the Insurance Agreement ;
3) notify the Insurer of the occurrence of an insured event; to provide the Insurer with all the information available to it, allowing to judge the causes, in the course and consequences of the insured accident, the nature and amount of the loss caused;

4) in case of any insured event, the consequence of which may be the occurrence of an insured event, immediately, but no later than 24 hours from the moment of its occurrence, contact the Assistance Company or the Insurer;
5) comply with the requirements of these rules, the terms of the Insurance Agreement, the prescriptions of the attending physician received in the course of providing medical care, the procedure established by the medical institution;
6) inform the Insured of the terms and conditions of insurance;
7) ensure, at the request of the Insurer, an examination of the Insured to assess the actual state of his health;
8) take measures to reduce losses from the insured event;
9) ensure the transfer to the Insurer of the right of claim to the person responsible for the occurrence of the insured event;
10) provide all documents and information requested by the Insurer necessary to comply with the requirements of the legislation of the Republic of Kazakhstan;
11) inform the Insurer about the state of insurance risk;
12) perform other actions provided for by the Insurance Agreement and the legislation of the Republic of Kazakhstan.

11.3. The insurer has the right to:
1) check the information and documents provided by the Insurant (Insured, Beneficiary), as well as the fulfillment by the Insurant (Insured, Beneficiary) of the requirements and terms of the Insurance Agreement;
2) independently find out the causes and circumstances of the event that has signs of an insured event, including sending requests to the competent authorities;
3) to require from the Insured (Insured, Beneficiary) the information necessary to establish the fact of the insured event, the circumstances of its occurrence;
4) to examine the Insured to assess the actual state of his health;
5) suspend/refuse to carry out transactions with money and (or) other property under the Insurance Agreement in order to comply with the requirements of the legislation of the Republic of Kazakhstan;
6) perform other actions provided for by the Insurance Agreement and the legislation of the Republic of Kazakhstan.

11.4. The insurer is obliged to:
1) familiarize the Insurant (Insured) with the Insurance Rules and, at his request, submit (send) a copy of the rules;
2) in the event of an insured event, make an insurance payment in the amount, procedure and terms established in the Insurance Agreement;
3) reimburse the Insured (Insured) for the expenses incurred by him/her to reduce losses in case of an insured event;
4) ensure the secrecy of insurance;
5) control the volume, terms and quantity of services provided in accordance with the terms of the Insurance Agreement;
6) refuse to carry out and suspend transactions with the money of the Insured (Insured, Beneficiary), as well as refuse to establish business relations with the Insured in accordance with the requirements of Article 13 of the Law of the Republic of Kazakhstan No 191-IV dated 28.08.2009. "On Combating the Legalization (Laundering) of Proceeds from Crime and the Financing of Terrorism";
7) perform other actions provided for by the Insurance Agreement and the legislation of the Republic of Kazakhstan.

11.5. The list of rights and obligations of the parties to this section is not exhaustive, certain obligations of the parties are provided for by other sections of these Rules, as well as by the Insurance Agreement.

12. CONSEQUENCES OF THE INCREASE IN INSURANCE RISK DURING THE VALIDITY PERIOD OF THE INSURANCE CONTRACT

12.1. During the validity period of the Insurance Agreement, the Insurant (Insured) shall immediately, but not later than 3 (three) business days, inform the Insurer in writing about significant changes in the circumstances that have become known to him/her, communicated to the Insurer at the conclusion of the Insurance Agreement, if these changes may significantly affect the increase in insurance risk.

12.2. In any case, the following changes are recognized as significant:

1) change in the territory of insurance;
2) change in the period of stay;
3) change in the purpose of the trip.
4) change in the number of people leaving;

12.3. The Insurer, notified of the circumstances entailing an increase in the insurance risk, has the right to demand a change in the terms of the Insurance Agreement and payment of an additional insurance premium in proportion to the increase in the insurance risk.

12.4. If the Insured (Insured) objects to changing the terms of the Insurance Agreement and/or additional payment of the insurance premium, the Insurer has the right to demand termination of the Insurance Agreement in accordance with the legislation of the Republic of Kazakhstan.

12.5. If the Insurant (Insured) fails to comply with the conditions of clause 12.2 of these Rules, the Insurer has the right to refuse to make the insurance payment

12.6. The Insurer shall not be entitled to demand termination of the Insurance Agreement if the circumstances leading to an increase in the insurance risk have already disappeared.

13. ACTIONS OF THE INSURED (INSURED) IN THE EVENT OF AN INSURED EVENT

13.1. Proof of the occurrence of an insured event, as well as the losses caused by it, lies with the Insured, the Insured, the Beneficiary.

13.2. In the event of any event that has signs of an insured event and/or the consequence of which may be the occurrence of an insured event, that is, before applying for a medical or other service specified in the Insurance Agreement, the Insured (Beneficiary) or another interested person is obliged to immediately, but no later than 24 hours from the moment of its occurrence, contact the Service Company by phone numbers specified in the Insurance Agreement and inform:

1) surname, name, number and validity period of the Insurance Agreement;
2) location of the Insured, contact phone numbers;
3) briefly describe what happened, a description of the disorders and the condition of the Insured, and what kind of medical care he needs.

13.3. After receiving instructions from the Assistance Company, the Insured must act in strict accordance with the instructions received.

13.4. In the event of an insured event provided for by the Insurance Agreement, the Service Company on behalf of the Insurer shall ensure the provision of services to the Insured in the amount of the selected category and within the insurance amount established by the Insurance Agreement.

13.5. In case of emergency, if an urgent call was not made before applying for medical services and the Insured is already receiving medical care, the Insured (his/her representative) shall:

1) immediately, as soon as the physical condition allows, inform the Assistance Company:

a) name, address and telephone number of the hospital to which the Insured is sent;

b) full name, address and phone number of the attending physician;

c) address of permanent residence and citizenship of the Insured;

d) the number of the Insurance Agreement.

2) provide, at the request of the Insurer and/or Assistance Company, documentation on treatment related to the insured event, as well as the opportunity to familiarize himself with medical documentation through the release of the attending physician from the obligation to observe medical confidentiality.

13.6. Timely application to the Assistance Company and coordination of the Insured's expenses related to the services covered in accordance with the Insurance Agreement is a prerequisite for making the insurance payment, except for the cases specified in clause 13.5 of these Rules.

13.7. In exceptional cases, due to the emergency situation or due to the absence of a representative office of the Assistance Company in the host country, or in other cases when the Insured (Insured, Beneficiary) cannot contact the Assistance Company, the Insured has the right to contact any doctor of any medical institution nearest to the place of the event and independently pay the costs for the medical care provided to him. At the same time, within 20 (twenty) calendar days from the date of the Insured's return to the country of permanent residence, the Insured (Insured, Beneficiary) is obliged to notify the Insurer of the occurrence of the insured event and provide the documents specified in Chapter 14 of these Rules. Failure to notify or untimely notification of the Insurer about the occurrence of an insured event is not a ground for refusal to make an insurance payment, if it is due to reasons beyond the control of the Insured (Insured, Beneficiary) or referred by the Insurance Agreement to valid, and the relevant documents confirming this fact are submitted.

13.8. In order to receive the insurance payment, the heirs or persons who have incurred the costs of providing medical services (repatriation in case of death of the Insured) within 20 (twenty) calendar days from the date of return of the Insured (repatriation of the Insured's body) to the country of permanent residence/citizenship, must submit to the Insurer a written application for payment with the relevant documents attached.

14. DOCUMENTS REQUIRED FOR CONSIDERATION OF THE ISSUE OF INSURANCE PAYMENT

14.1. In case of independent application of the Insured (Insured, Beneficiary), in order for the Insurer to make a decision on insurance payment, the Insurer must provide an application for insurance payment and the following documents:

1) original of the Insurance Agreement (duplicate);

2) originals of medical documents with their translation into the state or Russian languages with notarization, containing information about the diagnosis, state of health of the Insured at the time of applying for medical care, about the manipulations and treatment performed, or a medical document about a disease or other health disorder and the cost of services, which have undergone the procedure of apostille or legalization;

3) originals of prescriptions, bills, receipts for payment of medical services and services in accordance with the insurance program chosen by the Insured;
4) documents confirming the fact and causes of the occurrence of the insured event:
   - in case of road accidents - copies/originals of the protocol/acts of the authorized bodies of the country of residence of the road (police/militia);
   - in case of damage caused by third parties - a forensic medical examination report (expert opinion) on the assessment of the degree of harm to the health and life of the Insured, as well as a decision to involve the Insured as a Victim or another official document determining the causal relationship between the event and the infliction of harm to health and life, as well as the amount of damage;
   - in case of fire - a fire report.
5) a copy of the Insured's foreign passport with border control marks on crossing the state border of the Republic of Kazakhstan and the country that is the territory of insurance;
6) documents certifying the identity of the Insured/Beneficiary and the right to receive the insurance payment;
7) originals or copies of air and railway tickets, as well as tickets for water or road transportation;
8) in the event of the death of the Insured, the Insured/Beneficiary shall additionally provide:
   - copies of documents provided for by regulatory legal acts containing data on the cause of death of the Insured (conclusion of a forensic medical examination, death certificate indicating the cause);
   - original or copy of the death certificate;
   - the results of the post-mortem examination, if requested by the Insurer;
   - documents confirming medical evacuation or repatriation of the Insured's body: act of transportation, receipts, receipts confirming the cost of transporting the body of the deceased, transportation and preparation of the body for air transportation, cost of the coffin, funeral company services, consulting services.
9) in cases of return of minor children to the country of permanent residence and/or originals of air and/or car/railway tickets, as well as tickets for water or road transportation.

14.2. Documents for reimbursement of self-paid expenses are provided by the Insured or by a power of attorney issued by him to the recipient.

14.3. The specific list of documents is determined by the Insurance Agreement.

14.4. The burden of collecting documents lies with the Insured, the Insured and the Beneficiary.

14.5. The Insurer who accepted the documents is obliged to draw up a certificate in 2 (two) copies indicating the full list of documents submitted by the Applicant and the date of their acceptance. One copy of the certificate shall be issued to the Applicant, the second copy with the Applicant's mark of receipt shall be kept by the Insurer. In case the Insurant (Insured, Beneficiary) or their representatives do not submit all the documents provided for by this Chapter, the Insurer shall be obliged to notify them of the missing documents within 3 (three) business days from the date of submission of the last of the required documents in writing or by e-mail/SMS. When providing copies of documents, the Insured (Insured, Beneficiary) shall provide the original of such document for verification.

14.6. In case of failure to provide or untimely provision by the Insured (Insured, Beneficiary) or the person who incurred the costs of providing medical services, including the costs of repatriation of the application for insurance payment and the documents specified in clause 14.1. of these Rules, the Insurer has the right to refuse insurance payment.
14.7. The Insured is obliged to undergo a medical examination within 4 (four) working days from the date of receipt of the Insurer's request and submit its results in order to confirm the occurrence of an insured event, establish a diagnosis.
14.8. Documents in a foreign language are provided in translation into the state and/or Russian languages with notarization and with the passage of the apostille or legalization procedure.

15. PROCEDURE AND CONDITIONS FOR MAKING INSURANCE PAYMENTS

15.1. The insurance payment is made by the Insurer upon the occurrence of an insured event:
1) Assistance of the company, in case of the Insured's application to the Assistance;
2) To the insured/person who has incurred expenses for the provision of medical services, including repatriation costs, in the cases provided for in clause 13.7 of these Rules.
15.2. The amount of insurance payment for the consequences of one or more insured events that occurred during the Insured's stay abroad during the validity period of the Insurance Agreement may not exceed the maximum amount of liability (insurance amount) established for each insured event in accordance with these Rules and the Insurance Agreement.
15.3. **Procedure and conditions of insurance payments to the Assistance company:**
15.3.1. Expenses for services received by the Insured through the Assistance Company in the insurance territory shall be paid by the Insurer directly to the Service Company on the basis of invoices issued to it by the Assistance Company.
15.4. **Procedure and conditions of insurance payments to the Insured / Person who incurred costs in case of self-application:**
15.4.1. If it is impossible to contact the Assistance, the Insured has the right to independently receive medical care while paying for the services of a medical institution, while the Insured (Insured, Beneficiary) is obliged to inform the Insurer about the occurrence of the insured event without delay, but no later than 3 (three) business days from the date of the insured event, by calling the phone numbers specified in the Insurance Agreement.
15.4.2. Based on the results of consideration of the documents submitted by the Insured (Insured, Beneficiary) to confirm the occurrence of the insured event and the amount of damage caused, the Insurer shall take one of the following actions:
1) makes an insurance payment.
2) refuses to make an insurance payment
3) makes a decision on the impossibility to make or refuse to make an insurance payment.
15.4.3. The insurer shall make the insurance payment or refuse to make the insurance payment in the manner specified in these Rules.
15.4.4. The Insurer's decision on the impossibility to make or refuse to make the insurance payment shall be made if it is impossible to establish from the submitted documents the circumstances of the event that has occurred, the amount of damage caused as a result of the occurrence of such an event, the fulfillment by the Insurant (the Insured, the Beneficiary) of its obligations.

15.4.5. In turn, the impossibility of establishing the circumstances specified in the Insurer's decision does not allow the Insurer to make a decision on making or refusing to make an insurance payment, taking into account the provisions of the Insurance Rules, the terms of the Insurance Agreement/Appendices to these Rules.

15.4.6. In this case, the Insurer in its decision shall indicate which circumstances of the event and/or the amount of damage caused as a result of the occurrence of such an event, the facts of the Insured's (Insured, Beneficiary's) fulfillment of its obligations, cannot be established and what actions the Insured (Insured, Beneficiary) should take.

15.4.7. In any case, in order to receive the insurance payment, the Insured (Insured, Beneficiary) shall submit to the Insurer a written application in accordance with clause 13.7. of these Rules no later than 20 (twenty) days after returning to the country of permanent residence. In case of non-fulfillment of these requirements, the Insurer shall have the right to refuse the insurance payment, unless otherwise provided by the Insurance Agreement.

15.4.8. The amount of insurance payment shall be determined on the basis of original receipts and invoices, and if, under the terms of these Rules, the insurance payment is payable to the Beneficiary for the costs of providing medical services, including repatriation costs, its amount shall be determined in tenge at the official exchange rate of foreign currencies of the National Bank of the Republic of Kazakhstan as of the date of payment for services for the insured event.

15.4.9. The amount of losses is determined based on the actual expenses incurred by the Insured (persons accompanying him/her) on the basis of the documents specified in clause 14.1, minus the amount of the deductible, if it is provided for by the Insurance Agreement.

15.4.10. The insurance payment is made within the limits of the insurance amount established by the Insurance Agreement by paying for medical and other services under the Insurance Program provided for by the Insurance Agreement.

15.4.11. The insurance payment shall be made by non-cash payment by the Insurer of the invoices issued to it by the Assistance Company or by reimbursement of independently paid expenses for the rendered medical and other services to the Insured/Beneficiary in the event of an insured event provided for by the Insurance Agreement, subject to the provision of a full package of documents confirming the fact of receipt and payment for medical services.

15.4.12. The Insurer shall be exempt from making the insurance payment in terms of those losses that have arisen as a result of the fact that the Insured (Insured, Beneficiary) intentionally did not take reasonable and available measures to reduce possible losses.

15.4.13. Insurance payment in foreign currency shall be made in accordance with the procedure established by the legislation of the Republic of Kazakhstan on currency regulation.

15.4.14. The insurer shall make the insurance payment within 10 (ten) business days after it makes a decision on the insurance payment.

15.4.15. The deadline for consideration of documents and making insurance payment under voluntary insurance contracts of Insurants - individuals, after submission of all necessary documents to the Insurer, is no more than 15 (fifteen) business days.

15.4.16. In the event that the decision to make the insurance payment cannot be made within the established time limits, additional information or data to the submitted documents is required, the Insurer shall notify the Insurant – individual (Insured, Beneficiary) with an explanation of the reasons for the need to extend the terms of insurance payment. At the same time, the period does not exceed 15 (fifteen)

working days from the date of the deadline for consideration of documents for insurance payment, under voluntary insurance contracts of Insurants - individuals.

15.4.17. The Insurer's refusal to make the insurance payment may be appealed in court according to the jurisdiction of the actual location of the Insurer's head office, after sending a claim to the Insurer.

15.4.18. The procedure for consideration of insured events is carried out in writing and in electronic form by exchanging electronic information resources between the Insurer, the Insured (Insured, Beneficiary) and the organization for the formation and maintenance of the database.

15.5. The procedure for the exchange of electronic information resources between the organization for the formation and maintenance of the database and the Insurer, the Insurer and the Insurant (Insured, Beneficiary) shall be determined by the regulatory legal act of the authorized body.

16. TERMS OF TERMINATION OF THE INSURANCE CONTRACT

16.1. In addition to the grounds for early termination of the Insurance Agreement, on the grounds provided for in paragraph 1 of Article 841 of the Civil Code of the Republic of Kazakhstan, the Insurance Agreement is terminated in the following cases:

1) refusal of the Insured to travel due to visa refusal;
2) changes in the terms and information included in the Insurance Agreement;
3) cancellation of the Insurance Agreement at the initiative of the Insured, except for the case provided for in subparagraph 1 of this paragraph;
4) the Insurer has made an insurance payment in the amount of the insurance amount under the Insurance Agreement;
5) non-payment by the Insured of the next insurance premium when paying the insurance premium in installments;
6) expiration of the Insurance Agreement;
7) in other cases established by the legislation of the Republic of Kazakhstan or the Insurance Agreement.

16.2. In case of termination of the Insurance Agreement before the commencement of its validity on the grounds specified in subparagraphs 1) - 3) of paragraph 16.1. of these Rules, the insurance premiums paid to the Insurer shall be refunded in full, unless otherwise provided for in the Agreement.

16.3. In case of termination of the Insurance Agreement after the commencement of its validity on the grounds specified in sub-paragraph 1) of paragraph 16.1. of these Rules, the insurance premiums paid to the Insurer shall be refunded in full subject to a written notice to the Insurer within 3 (three) business days from the date of commencement of the Insurance Agreement, unless otherwise provided for in the Agreement.

16.4. In case of termination of the Insurance Agreement after the commencement of its validity on the grounds specified in subparagraphs 1) - 3) of paragraph 16.1. of these Rules, the insurance premiums paid to the Insurer shall be refunded: a part of the insurance premium for the unexpired insurance period minus the costs incurred for conducting business, the amount of which is up to 30% of the total amount of the insurance premium, within 30 calendar days from the date of submission to the Insurer of an application for early termination of the Agreement, unless otherwise provided by the legislation of the Republic of Kazakhstan or the Insurance Agreement.

16.5. In case of refusal of the Insured-individual from the Insurance Agreement, within fourteen calendar days from the date of its conclusion, the Insurer shall be obliged to return to the Insurant-individual the insurance premium (insurance premiums) received minus a part of the insurance premium (insurance premiums) in proportion to the time

during which the insurance was in effect and the costs associated with the termination of the Insurance Agreement, not exceeding ten percent of the insurance (received) received premiums (insurance contributions).

16.6. In cases where early termination of the Agreement is caused by non-fulfillment of its terms through the fault of the Insurer, the latter is obliged to return to the Insured the insurance premium or insurance premiums paid by him in full.

17. LIABILITY OF THE PARTIES

17.1. In case of untimely implementation of insurance payment, the Insurer is obliged to pay a penalty to the Beneficiary in the manner and amount established by Article 353 of the Civil Code of the Republic of Kazakhstan.

17.2. The Party that has not fulfilled or improperly fulfilled its obligations under the Insurance Agreement shall not be liable for non-fulfillment/improper fulfillment of obligations if it proves that proper performance was impossible due to force majeure, that is, extraordinary and unavoidable circumstances under the given conditions.

17.3. Force majeure includes, but is not limited to: floods, fires, earthquakes and other natural disasters, wars or military actions of any nature, blockades, prohibitions of state bodies, civil unrest. A specific list of force majeure circumstances may be provided for in the Insurance Agreement.

17.4. The party experiencing force majeure is obliged to notify the other party of the occurrence of such circumstances within 3 (three) business days, unless otherwise provided for in the Insurance Agreement.

17.5. The effect of force majeure circumstances must be confirmed by the relevant documents of the competent authorities.

17.6. The liability of the parties provided for in this section may be changed (supplemented) in accordance with the terms of the Insurance Agreement.

18. DISPUTE RESOLUTION PROCEDURE

18.1. Any disputes and/or disagreements arising out of or in connection with the Agreement shall be resolved through negotiations.

18.2. In the event of disputes, the Parties are obliged to comply with the following pre-trial dispute settlement procedure:

- In the event of a dispute, the Party is obliged to file a written claim with the other Party and receive a response to the claim. If the Party refuses to satisfy the requirements set forth in the claim, or does not give a written response to the claim within 15 (fifteen) business days from the date of receipt of the claim, or fails to take actions evidencing partial or full recognition of the claim, the Party shall apply to the insurance ombudsman to resolve the dispute. Resolution of the dispute, in fact, by the insurance ombudsman is a mandatory stage of compliance with the pre-trial stage of dispute resolution. At the same time, the execution of the decision of the insurance ombudsman for the Insured (Insured, Beneficiary) is not mandatory.

- In the event of a dispute regarding the contestation of the amount of insurance payment, the Insurant (Insured, Beneficiary) shall be obliged to receive the undisputed part of the insurance payment, after which he shall perform the actions specified in subparagraph 1) of this paragraph.

18.3. If an agreement is not reached and it is impossible to settle the dispute in a pre-trial manner, the Parties file a claim with the court of the Medeu district of Almaty (if one party to the dispute is an individual or) or the specialized inter-district economic court

of Almaty (if the dispute is between legal entities or individual entrepreneurs), that is, contractual jurisdiction is established.

18.4. These Insurance Rules are drawn up in 2 (two) copies in the state and Russian languages. In case of discrepancy between the content of the text of these Rules drawn up in the state language and the content of the text of these Rules drawn up in Russian, the Parties shall be guided by the text of these Rules drawn up in Russian.

19. ADDITIONAL CONDITIONS

19.1. The insurance contract may provide for other conditions that do not contradict the legislation of the Republic of Kazakhstan.

19.2. On the basis of these Rules, the Insurer has the right to develop insurance programs (insurance contracts) with a different set of insurance risks and other insurance conditions that do not contradict the legislation of the Republic of Kazakhstan.

19.3. In case of non-compliance of the content of the Insurance Agreement with these Rules, the terms of the Insurance Agreement shall apply, if it is expressly stipulated in the Insurance Agreement.

19.4. To the extent not regulated by these Rules, the current legislation of the Republic of Kazakhstan shall apply.