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

RULES

VOLUNTARY INSURANCE
ACCIDENTS

Almaty, 2025

CONTENT:

1. GENERAL PROVISIONS

1.1. These Rules have been developed in accordance with the class of insurance "voluntary accident insurance" in the "general insurance" industry.

1.2. On the terms and conditions of these Rules, Basel Insurance Company JSC, hereinafter referred to as the Insurer, enters into a Voluntary Accident Insurance Agreement (hereinafter referred to as the Agreement) with a capable individual (regardless of citizenship) and a legal entity (regardless of the form of ownership).

1.3. The following concepts are used in these Rules:

1) **Insurer** - Insurance Company Basel JSC
2) **Insured** – an adult individual or legal entity who has entered into an Agreement with the Insurer.
3) **The Insured** is a capable individual in respect of whom insurance is carried out (the age of those accepted for insurance is stipulated by the terms of the Agreement). Unless otherwise provided by the Agreement, the Insured is at the same time the Insured.
4) **Beneficiary** is a person who, in accordance with the Agreement, is the recipient of the insurance payment. Unless otherwise provided by the Agreement, the Insured is at the same time the Beneficiary.
5) **Insured event** is an event that has signs of probability and randomness of its occurrence, provided for by the Agreement, with the occurrence of which the Insurer's obligation to make an insurance payment arises.
6) **Insurance amount is the** amount of money within which the Insurer undertakes to make the insurance payment. The insurance amount is the maximum amount of the Insurer's liability during the validity period of the insurance cover.
7) **Insurance premium** is the amount of money that the Insured is obliged to pay to the Insurer for the latter's assumption of obligations to make an insurance payment to the Beneficiary in the amount determined by the Agreement.
8) **Insurance indemnity is the** amount in tenge paid by the Insurer to the Beneficiary within the insured amount in the event of an insured event.
9) **Death** is the biological death of the Insured, which has a causal relationship with the accident that occurred during the period of insurance coverage under the Agreement.
10) **Accident** is a sudden, short-term incident that occurred against the will of a person as a result of an external mechanical, electrical, chemical or thermal impact on the Insured's body, which occurred during the validity period of the Agreement, namely: electric current, lightning strike, sunstroke, attack of intruders and/or animals, bites of snakes, insects, fall of any object or the Insured himself, explosion, burn, frostbite, drowning, sudden suffocation as a result of accidental ingestion of a foreign body into the respiratory tract, accidental acute poisoning by poisonous plants, chemicals (industrial or domestic), medicines, low-quality food products, as well as injuries received during the movement of vehicles or their crash, when using machines, mechanisms, weapons and all kinds of tools, resulting in harm to health, injury or death of the insured. *Any forms of acute, chronic and hereditary diseases, other sudden lesions* do not belong to accidents.
11) **Insurance territory** is the territory specified in the Agreement, within which the insurance coverage in relation to the insured object is valid.
12) **Disability** is a functional disorder of the body, in which the impairment leads to the inability to carry out habitual actions, can lead to the loss of professional or general working capacity. A distinction is made between temporary and permanent disability.
In case of temporary disability, the loss is temporary and reversible, a certificate of temporary disability is issued for a limited number of days in accordance with the requirements of the legislation of the Republic of Kazakhstan.

In case of permanent disability, the loss is permanent and irreversible, a document of the authorized body is issued to determine the disability and its group.

In case of loss of ability to work that did not result in disability, the loss is permanent and reversible, a document of the authorized body is issued to determine the percentage of loss of ability to work.

13) **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".

1.4. The Insured has the right to appoint any person to receive insurance payments under the Agreement (Beneficiary) at the conclusion of the Agreement, as well as to replace him/her at his/her discretion before the occurrence of the insured event, notifying the Insurer in writing, except for cases when the replacement of the Beneficiary is prohibited under the terms of the Agreement, without the written consent of the Beneficiary.

2. OBJECT OF INSURANCE

2.1. The object of insurance is the property interests of the Insurant (Insured) that do not contradict the legislation of the Republic of Kazakhstan, related to causing harm to the life and health of the Insured Person, his death, loss of ability to work (full or partial), (general or professional) or other harm to the health of the Insured that occurred as a result of an accident.

2.2. The Insurer's obligation to make an insurance payment shall apply only to the insured events specified in clause 3.1. of these Rules, which happened to the Insured during the validity of the Agreement and in the territory specified in the Agreement.

3. INSURED EVENT

3.1. An insured event is an event that occurred as a result of an accident during the insurance period and in the territory of insurance. Insured events must be confirmed by documents issued by competent state bodies in accordance with the procedure established by the legislation of the Republic of Kazakhstan (authorized bodies, court, medical institutions, etc.).

3.2. Insured events are:

1) death of the insured as a result of an accident;
2) establishment of the category of "disabled child" to the insured as a result of an accident;
3) establishment of temporary disability of the insured as a result of an accident;
4) establishment of disability to the insured with the assignment of a group as a result of an accident;
5) establishment of the degree of disability of the insured (general or professional), which does not entail the establishment of disability;
6) injury (mutilation) as a result of an accident.

3.3. A specific list of insured risks (insured events) is specified in the Contract by agreement of the parties.

3.4. Proof of the occurrence of an insured event, as well as the amount of damage caused by it, lies with the Insurant (Insured) and (or) the Beneficiary in accordance with paragraph 4 of Article 817 of the Civil Code of the Republic of Kazakhstan.

4. EXCLUSIONS FROM INSURED EVENTS AND INSURANCE LIMITATIONS. GROUNDS FOR THE INSURER TO AVOID INSURANCE PAYMENT

4.1. Unless otherwise stipulated by the Agreement, the Insurer has the right to fully or partially refuse the Beneficiary to pay the insurance indemnity, if during the period of validity of the insurance coverage there were:

1) 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;
2) commission by the Insured (Insured/Beneficiary) of an intentional crime that is in a direct causal relationship with the occurrence of the insured event;
3) communication by the Insured (Insured) and (or) the Beneficiary to the Insurer of knowingly false, incorrect information about the object of insurance, insurance risk, insured event and its consequences;
4) failure to notify / untimely notification of the Insurer about the occurrence of an insured event in accordance with the provisions of these Rules or the Agreement. The fact of notifying the Insurer of the occurrence of an insured event (an event that may lead to the occurrence of an insured event) within the period specified in these Rules and (or) the Agreement is directly related to the obligation (possibility) of the Insurer to make an insurance payment. Accordingly, the Parties are aware and hereby confirm that failure to notify/untimely notify the Insurer of the insured event within the time limits established by these Rules or the Agreement deprives the latter of the opportunity to make the insurance payment and this does not require additional evidence in the event of an insured event;
5) obstruction by the Insured (Insured/Beneficiary) in the investigation by the Insurer of the circumstances of the occurrence of the insured event and in establishing the amount of damage/loss caused by him/her;
6) deliberate failure by the Insured (Insured) to take reasonable and available measures to reduce possible harm to life and health;
7) waiver of the Insurant's (Insured's) right of claim to the person responsible for the occurrence of the insured event, as well as refusal to transfer to the Insurer the documents necessary for the transfer of the right of claim to the Insured;
8) in other cases provided for by the Agreement.

4.2. Unless otherwise stipulated by the Agreement, the insurance payment is not made in case of harm to health or life, which was a direct or indirect result of:

1) hostilities (regardless of whether war has been declared), civil war, insurrection, revolution, mutiny, terrorism, civil unrest of all kinds, riots or strikes);
2) radioactive contamination, the impact of a nuclear explosion, radiation or radioactive contamination, ionizing exposure;
3) suicide or attempted suicide or deliberate self-harm of the Insured (Insured), including those in a state of insanity, mental disorder, dementia, insanity, affect, including in a state caused by medicines not prescribed to him by a doctor.
4) any diseases and their consequences, no matter how they arise or whatever they are called;
5) stay of the Insured (Insured) at the time of the accident under the influence of alcohol, narcotics, toxic intoxication or under the influence of psychotropic or potent drugs;
6) poisoning of the Insured (Insured) with ethanol, alcoholic beverages, potent (including narcotic) drugs, the use of psychotropic drugs, if the latter were taken without a doctor's prescription, as well as toxic substances taken for the purpose of intoxication, as well as poisoning with an unknown (unidentified) poison/substance;

7) neuroses, psychoneuroses, psychopathies, psychoses, mental or emotional disorders or mental illnesses (including, but not limited to, manic-depressive states);
8) death or any harm to health, if they do not have a causal relationship with the accident;
9) any sudden and unforeseen bodily injury or disease of any organ, if it was facilitated or aggravated by injury to health, physical defects, tissue degeneration processes or physical defects that existed before the date of the beginning of the insurance period (in this case, damage to health, physical defects, tissue degeneration processes or physical disabilities that existed before the date of the beginning of the insurance period are understood as diseases diagnosed by a doctor that existed before the start of the insurance period. In cases where such a diagnosis has not been made, such conditions are those that, in the opinion of the doctor, the Insured (Insured) should have known about before the beginning of the insurance period).
10) practice or participation by the Insured (Insured) in any professional or amateur sports, active recreation, participation in events/entertainment with elements of sports, hang gliding, parachuting, aviation sports/entertainment, mountaineering/rock climbing, speleology, scuba diving with the use of breathing apparatus, skiing/entertainment, surfing, hunting, horseback riding, cycling, motorcycle, moped and/or a scooter (jet ski);
11) participation of the Insured in auto, moto, bicycle races or competitions as a driver or participant;
Unless the above sports risks were additionally taken into account when concluding the insurance contract.

4.3. The Insurer shall be exempt from entering into the Agreement if it turns out that at the time of insurance the Insured has already been assigned a disability group, loss of ability to work without assignment of disability, or an occupational disease has been diagnosed. If it turns out that the Insured at the time of insurance has already had serious injuries that may subsequently lead to disability, but which he did not indicate in the application, the Insurer also has the right to refuse to make the insurance payment, provided that evidence is provided of knowingly false information on the part of the Insured/Insured.

5. PROCEDURE FOR DETERMINING THE INSURED AMOUNT. FRANCHISE

5.1. The insurance amount is determined by the parties at their discretion, and is specified in the Agreement.
5.2. The Agreement may establish the aggregate amount of liability, in which case the amount of all insurance payments under the Agreement may not exceed this established amount, the maximum limit of liability - for each type of insured event, the maximum limit of liability for each insured person or group of insured.
5.3. After the insurance payment is made, the insurance amount in respect of the relevant Insured (Insured) is reduced by the amount of this payment. Reduction of the insurance amount is made from the date of insurance payment.

6. PROCEDURE FOR DETERMINING THE INSURANCE PREMIUM

6.1. The amount of insurance premiums (tariff) depends on various criteria; age of the insured, profession (type of work performed), number of insured, degree of exposure to risks (statistics of the Insured's insured events), as well as other factors affecting the degree of risk of occurrence of an insured event.
6.2. Insurance premiums may be different for different insurance programs (insurance products). The difference depends on the list of insured events, the insurance period, the territory of insurance, in any case, the amount of the premium under the Contract is determined by the agreement of

the parties for each insured object separately or as a whole under the Contract (if the risk accepted for insurance is homogeneous) according to the data provided in the insurance application.

6.3. The insurance premium is payable as a lump sum payment for individuals (Insureds) and non-cash payment for legal entities (Insureds) in a lump sum or in installments in the form of periodic insurance premiums to the Insurer's bank account in the manner prescribed by the Agreement. The amount of the insurance premium is fixed in the Contract in absolute amount in the national currency.

6.4. 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.

6.5. 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.

6.6. The insurance cover begins on the next day from the date of receipt of the insurance premium (first insurance installment) to the Insurer's bank account or cash to the Insurer's cash desk.

7. PROCEDURE FOR CONCLUDING A CONTRACT

7.1. These Rules provide for the conclusion of the Agreement in writing, electronic form, by the Insured's accession to these Insurance Rules developed by the Insurer unilaterally (adhesion agreement), and the issuance by the Insurer of an insurance policy to the Insured.

7.2. The Agreement is concluded on the basis of an insurance application filled out by the Insured, which is an integral part of it. The insurer has the right to change the format of the application - questionnaire. In the application, the Insured is obliged to indicate accurate and complete information in accordance with the questions posed by the Insurer.

7.3. Upon conclusion of the Agreement, the Insured shall inform the Insurer of all circumstances known to the Insured that are essential for the assessment of the insurance risk.

7.4. At the request of the Insurer, copies of identity documents of the Insured and all insured persons shall be attached to the application.

7.5. In order to conclude the Agreement, the Insurer may request additional documents and information characterizing the insurance risk from the Insured.

7.6. The Insured shall be responsible for the accuracy and completeness of the data provided for the conclusion of the Agreement, including responses to the Insurer's written requests.

7.7. The Insurer has the right to refuse to conclude the Agreement with the Insured without giving reasons.

8. TERM AND PLACE OF VALIDITY OF THE CONTRACT

8.1. The contract is concluded for a minimum period of 3 days, a maximum period of 12 months and enters into force on the day following the day of payment of the insurance premium. The day of payment of the insurance premium is the day of receipt of money to the bank account or cash desk of the Insurer.

8.2. Unless otherwise provided for in the Agreement, the period of validity of the insurance cover coincides with the term of the Agreement.

8.3. Unless otherwise provided for in the Agreement, the Agreement shall terminate at 24:00 on the day specified in the Agreement as the day of termination of the Agreement.

8.4. The insurance territory is the Republic of Kazakhstan or the WHOLE world (excluding countries of military operations), unless otherwise specified in the Agreement.

9. RIGHTS AND OBLIGATIONS OF THE PARTIES

9.1. **The Insurer shall have the right to:**

1) check the information and documents provided by the Insurant (Insured), as well as the fulfillment by the Insurant (Insured) of the requirements and terms of the Agreement;
2) to assess the insurance risk;
3) upon receipt of a notification of the circumstances entailing an increase in the insurance risk, to demand a change in the terms of the Agreement or the loss of additions to the insurance premium in proportion to the increase in risk;
4) to demand termination of the Agreement if the Insurant communicates false information about risks to the Insurer when entering into the Agreement, if these changes may significantly affect the increase in the insurance risk, or if the Insured objects to the change in the terms of the Agreement or additional payment of the insurance premium in proportion to the increase in the degree of risk;
5) independently find out the causes and circumstances of the event that has signs of an insured event, including requesting from the relevant state bodies and organizations, based on their competence, documents confirming the fact of occurrence of the insured event and the amount of damage caused;
6) to demand from the Insurant (Insured) the information necessary to establish the fact of the insured event, the circumstances of its occurrence;
7) refuse to make an insurance payment in full or in part on the grounds provided for by these Rules and the Agreement;
8) suspend/refuse to carry out transactions with money and (or) other property under the Agreement in order to comply with the legislation on combating the legalization (laundering) of proceeds from crime and the financing of terrorism;
9) perform other actions provided for by these Rules or the Contract or the current legislation of the Republic of Kazakhstan.

9.2. **The Insurer shall:**

1) familiarize the Insured with these Rules and, at his request, provide (send) a copy of these Rules;
2) ensure the secrecy of insurance;
3) in the event of an insured event, make an insurance payment in the amount, procedure and terms established in these Rules and (or) the Agreement;
4) send a written reasoned refusal to make the insurance payment to the Insured and the Beneficiary in accordance with these Rules and (or) the terms of the Agreement;
5) reimburse the Insured (Beneficiary) for the expenses incurred by him to reduce losses in case of an insured event;
6) in cases where the Insured (Insured) or the victim (Beneficiary) or their representative fails to submit all the documents necessary for the insurance payment, notify them of the missing documents within 10 (ten) working days from the date of establishing the fact of lack of documents;
7) perform other actions provided for by these Rules or the Contract or the current legislation of the Republic of Kazakhstan.

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

1) require the Insurer to explain the terms and conditions of insurance, its rights and obligations under these Rules and the Agreement;
2) to receive a duplicate of the Agreement, in case of loss of the original;
3) to the secrecy of insurance;
4) to early termination of the Agreement;
5) to change the insurance risk with a commensurate change in the insurance premium;

6) to challenge in the manner established by the legislation of the Republic of Kazakhstan, the Insurer's refusal to make the insurance payment or to reduce its amount;
7) perform other actions provided for by these Rules or the Agreement and the current legislation of the Republic of Kazakhstan.

9.4. **The Insurant shall:**

1) when entering into the Agreement, inform the Insurer of all circumstances known to it that are essential for the assessment of insurance risk and the Insurer's decision to conclude the Agreement;
2) pay insurance premiums in the amount, procedure and terms established by the Agreement;
3) during the validity period of the Agreement, immediately, but not later than 3 (three) business days from the moment when he became aware, inform the Insurer about changes in the state of insurance risk;
4) take measures to prevent or reduce losses from an insured event;
5) familiarize the Insured with the Terms and Conditions of the Agreement;
6) comply with the terms of the Agreement (violation of the terms of the insurance contract by the Insured is regarded as a violation of the terms of the insurance contract by the Insured);
7) in case of an increase in the degree of risk, make changes to the Agreement and/or pay an additional insurance premium within 5 (five) business days from the date of receipt by the Insured of the Insurer's notice of amendment of the Agreement and (or) additional payment of the insurance premium;
8) provide all documents and information requested by the Insurer necessary to comply with the requirements of the legislation of the Republic of Kazakhstan;
9) perform other actions provided for by these Rules and/or the Agreement and the current legislation of the Republic of Kazakhstan.

9.5. **In the event of an insured event, the Insured/Insured shall:**

1) notify the Insurer of the occurrence of an event that has signs of an insured event no later than 3 (three) business days from the date of occurrence of the insured event by sending it a written application (telegram, telephone message, electronic message), unless otherwise stipulated by the Agreement.
2) provide the Insurer with all the information available to it that allows it to judge the causes, course and consequences of the insured event, the nature and amount of the loss caused (however, the Insurer's actions to clarify the circumstances of the insured event are not the basis for recognizing the right to receive the insurance payment);
3) take reasonable measures available in the circumstances to prevent or mitigate possible losses;
4) immediately report the incident to the competent authorities;
5) assist the Insurer's representative in clarifying the causes and circumstances of the occurrence of the insured event, including providing the Insurer with all information and documentation available to him/her, allowing to judge the causes, course and consequences of the insured event, the nature and extent of the damage caused;
6) immediately notify the Insurer in writing of receipt of any compensation (compensation) for losses caused as a result of the insured event from third parties;
7) if the Insurer deems it necessary to appoint its representative to protect the interests of both the Insurer and the Insured, in connection with the occurrence of an insured event, to issue a power of attorney or other necessary documents to protect such interests to the persons specified by the Insurer. The Insurer has the right, but not the obligation, to represent the interests of the Insured in court or otherwise exercise legal protection of the Insured in connection with the occurrence of an insured event;

8) bear the burden of proof of the occurrence of the insured event, as well as the losses caused by it, including payment for the examination, visit of experts to the scene of the accident, involvement and consultations of specialists, collection of necessary documents, etc.;
9) perform other actions provided for by the Contract, these Rules and the legislation of the Republic of Kazakhstan.
10) ensure the transfer to the Insurer of the right of claim to the person responsible for the occurrence of the insured event.
11) The obligations specified in this clause may be changed or supplemented by the Agreement.

9.6. **The beneficiary has the right to:**

1) require the Insurer to explain the terms and conditions of insurance, its rights and obligations under these Rules and the Agreement;
2) submit a claim for insurance payment to the Insurer;
3) in the event of an insured event, receive an insurance payment in the manner and on the terms provided for by these Rules and the Agreement;
4) to challenge in the manner established by the legislation of the Republic of Kazakhstan, the Insurer's refusal to make the insurance payment or to reduce its amount;
5) perform other actions provided for by these Rules or the Contract or the current legislation of the Republic of Kazakhstan.

9.7. The list of rights and obligations of the parties to this section is not exhaustive, certain obligations of the parties are provided for in other sections of these Rules, and may be supplemented / expanded / reduced / changed in the Agreement.

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

10.1. To consider the issue of insurance payment, the Insured/Beneficiary must provide the Insurer with the following documents:

1) an application for insurance payment indicating the Beneficiary's bank details;
2) a copy of the Agreement;
3) an application for the occurrence of an insured event indicating the circumstances of the occurrence of the insured event, date, reasons and other data necessary for the Insurer to make an appropriate decision;
4) a copy of the document allowing to conduct a proper check of the client in accordance with the current legislation of the Republic of Kazakhstan and the Insurer's internal documents;
5) <u>in case of death</u>: originals or notarized copies of the medical report on death, a notarized copy of the death certificate of the authorized body indicating the cause of death, a copy of the autopsy report, (in case the autopsy was not performed - a copy of the relative's application for refusal to perform an autopsy, a copy of the certificate from the pathological and anatomical hotel, on the basis of which the death certificate is issued);
6) in case of disability of the Insured: a copy of the MSEC certificate on the establishment of disability;
7) in case of determination of the degree of disability of the Insured (general or professional), which does not entail the establishment of disability - copies of the MSEC certificate on the determination of the degree of disability;
8) if the Insured is found to have temporary disability - copies of certificates of temporary disability;
9) if the Insured is injured: a certificate from the trauma center; X-ray if indicated;
10) a copy of the industrial accident report Form N-1 (in case of injuries at work);

11) a copy of the act of special investigation of an accident at work (in case of injuries at work);
12) a copy of a doctor's death certificate or a death certificate indicating the exact cause of death;
13) notarized copies of certificates of disability, assignment of a disability group indicating the exact diagnosis on the basis of which disability was assigned from authorized bodies;
14) sick leave certificates (sick leaves) with the seal of the medical institution, signatures of the attending physician, the head of the department and the chief physician of the medical institution;
15) documents from a medical institution confirming the degree of loss of health as a result of an accident, the degree of damage caused to health as a result of injury (certificates from the trauma center of the admission department, extracts from the medical history) with the seal of the medical institution, signatures of the attending physician, the head of the department and the chief physician of the medical institution;
16) outpatient card, medical history or extracts from these documents, certified by an authorized person and sealed by the relevant medical institution;
17) copies of documents of authorized bodies confirming the fact of the accident (documents of internal affairs bodies, prosecutor's office, investigation, inquiry; judicial authorities; fire supervision bodies);
18) a copy of the document confirming the absence of alcohol, narcotic, toxic, psychotropic or potent substances in the Insured's blood at the time of the accident;
19) documents confirming the beneficiary's right to receive insurance payment in the event of the death of the policyholder (certificate of inheritance);
20) certificate of the guardianship and guardianship authorities issued to the guardian / trustee on consent to the disposal of property belonging to the Beneficiary (if the beneficiary is a minor or incapacitated, a partially capable person).

If the accident occurred during a road traffic accident (hereinafter referred to as an accident), fire, attack by third parties, then in addition to the above list the following documents must be submitted from the relevant authorized bodies, internal affairs bodies, inquiry departments, fire supervision bodies, judicial and other law enforcement agencies:

1) protocol of the authorized bodies on the incident;
2) resolution on an administrative offense (if any);
3) accident scheme;
4) supplement to the incident report;
5) explanatory statements of participants and witnesses of the incident;
6) protocols of medical examination of the injured Insured;
7) a court decision that has entered into force;
8) decisions of authorized bodies for damage assessment (expert opinions).

If necessary, the Insurer has the right to require a medical examination of the Insured/Insured in a medical institution, while the costs are paid by the Insurer.

10.2. The procedure and form of drawing up the submitted documents shall comply with the current legislation of the Republic of Kazakhstan, if it is provided for them. Unless otherwise provided by the Rules/Agreement, the documents shall be submitted to the Insurer in the original or in the form of a copy notarized or certified by the original seal and signed by an authorized person of the competent organization.

10.3. If necessary, the Insurer has the right to request documents and information related to the insured event from law enforcement agencies and other organizations that have information about the circumstances of the occurrence of the insured event, and also has the right to independently find out the causes and circumstances of the insured event.

10.4. A specific list of documents may be provided for in the Insurance Agreement.

11. CONSIDERATION BY THE INSURER OF THE ISSUE OF INSURANCE PAYMENT

11.1. 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.

11.2. The insurer shall make the insurance payment or refuse to make the insurance payment in the manner specified in these Rules.

11.3. 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.

11.4. 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.

11.5. 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.

12. PROCEDURE AND CONDITIONS FOR MAKING INSURANCE PAYMENTS

12.1. The insurance indemnity shall be made by the Insurer on the basis of the Insured's written application for the insurance indemnity and the documents submitted by the Insured.

12.2. Unless otherwise provided by the Agreement, in the event of an insured event, the insurance payment under the Agreement is made minus the previously made insurance payments as a percentage of the insured amount:

- ✓ Death – 100% of the sum insured (may or may not include the costs of repatriation of the body);
- ✓ disabled child – 80%;
- ✓ disability of the 1st group – 80%;
- ✓ disability of the 2nd group – 60%;
- ✓ disability of the 3rd group – 40%;
- ✓ loss of temporary ability to work - 1 MCI (on the day of insurance payment) for each day of sick leave, for a period not exceeding 30 days, unless otherwise stipulated by the terms of the Agreement, but not more than 20% of the insurance amount;
- ✓ in case of injuries that caused the loss of ability to work (general or professional) that did not result in the establishment of disability, payment is made in the amount of 10% of the insurance amount;
- ✓ In case of injuries (mutilations), another form of calculation of losses may be applied.

In any case, the amount of the insurance payment and the total amount of insurance payments may not exceed the sum insured. The Agreement may determine a different amount of insurance payments. If, as a result of the event that led to the occurrence of the insured event, the Insured's health deteriorates (death or disability of a higher group), the Insurer, on the basis of the application received from the Beneficiary, shall recalculate the amount of the insurance payment in accordance with the procedure and amount

determined by the Agreement, and taking into account the previously made, but within the limits of the insurance amount established under the Agreement.

- ✓ The insurance payment is made in the national currency - tenge.
- ✓ Unless otherwise provided for by the Agreement, the Insurer, upon receipt of the necessary documents on the claimed insurance event within 15 (fifteen) business days, shall make an appropriate decision on the insurance payment or refusal to make the insurance payment. If the Insurer has made a decision to refuse the insurance payment, it shall reasonably motivate the reason for the refusal in writing.
- ✓ Unless otherwise provided for by the Agreement, when making a decision to recognize the claimed event as an insured event, the Insurer shall make an insurance payment no later than 15 (fifteen) business days after the decision on payment is made. At the same time, the term of insurance payment may be suspended for up to 3 months if it is necessary to obtain additional documents and (or) information on the claimed insurance event; if necessary, apply to law enforcement agencies and other organizations that have information about the circumstances of the claimed insured event; as well as for the purpose of complying with the legislation on combating the legalization (laundering) of proceeds from crime and the financing of terrorism.

12.3. 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.

12.4. 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.

12.5. The insurance indemnity may be made to the Insured (who is not the Beneficiary) after the Beneficiary's written refusal to receive the insurance indemnity.

12.6. 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.

12.7. 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.

13. SUBROGATION

13.1. The Insurer that has made the insurance payment shall receive the right of claim that the Insured has against the person responsible for losses compensated as a result of insurance within the amount paid.

13.2. Upon receipt of the insurance indemnity, the Insurant shall be obliged to transfer to the Insurer all the documents and evidence available to him, and to inform him of all the information necessary for the Insurer to exercise the right of claim transferred to him.

13.3. The right of claim transferred to the Insurer shall be exercised at the request of the Insurer, even if it is not expressly provided for in the Agreement.

13.4. If the Insurant has waived his right of claim against the person responsible for the losses compensated by the Insurer, or the exercise of this right has become impossible through the fault of the Insured, the Insurer shall be released from making the insurance payment in full or in the relevant part and shall have the right to demand the return of the overpaid amount.

14. AMENDMENTS AND ADDITIONS TO THE AGREEMENT

14.1. Amendments and additions to the Agreement are made by mutual consent of the parties, on the basis of a written application (notification) of one of the Parties.

14.2. From the moment of receipt of the application of one of the Parties until the moment of making a decision, the Agreement is valid on the same terms.

14.3. Amendments and additions to the Agreement concluded in accordance with these Rules shall be formalized by drawing up and signing an additional agreement to the Agreement.

14.4. All changes and additions to the Agreement are legally binding subject to their written execution and signing of an additional agreement by authorized representatives of both Parties.

14.5. In case of exclusion / addition / replacement of the Insured, the Insured shall notify 1 (one) business day before making such changes to the Insurer's Agreement, indicating the reason (dismissal of the employee/hiring of a new employee), the Agreement in relation to the excluded Insured shall be terminated on the next day after receipt of the notice of dismissal. The insurance coverage in respect of the new Insureds specified in the agreement to the Agreement comes into force after the date of signing the Agreement by the parties and payment of the additional insurance premium, if it is calculated in the agreement. Admission of new Insured Persons is carried out for a period not exceeding the term of the main Agreement.

14.6. The basic principles of calculating the bonus in case of these changes will be specified in the Agreement.

14.7. In the case of insurance for a period of less than 12 months, the following premium calculation table applies:

Term of insurance (actual number of days of insurance for the insured)	The amount of the insurance premium per Insured as a percentage of the annual insurance premium calculated under the Agreement
Up to 1 month (30 days)	20%
Up to 2 months (60 days)	30%
Up to 3 months (90 days)	40%
Up to 4 months (120 days)	45%
Up to 5 months (150 days)	50%
Up to 6 months (180 days)	60%
Up to 7 months (210 days)	65%
Up to 8 months (250 days)	70%
Up to 9 months (280 days)	80%
Up to 10 months (30 days)	90%
Up to 11 months (330 days)	95%
Up to 12 months (365 days)	100%

14.8. In case of exclusion from the List of the Insured, in respect of which insurance payments have not been made, replacement with another newly admitted Insured may be made, or a part of the insurance premium may be refunded minus the insurer's administrative costs incurred for maintaining the Agreement in the amount of 25% of the paid annual insurance premium. The refund amount is calculated minus the amount of withholding in proportion to the expired period of the Insurance Agreement.

14.9. The expired term of the contract is determined in proportion to the calendar months, while an incomplete month is counted as a full month.

14.10. A new Insured who has been replaced is subject to the same insurance program as the excluded Insured.

15. TERMS OF TERMINATION OF THE CONTRACT

15.1. In addition to the grounds for early termination of the Agreement provided for by the legislation of the Republic of Kazakhstan, the Agreement shall be terminated early in the following cases:
1) non-payment by the Insured of the next insurance premium when paying the insurance premium in installments;
2) expiration of the Agreement;
3) termination of the Agreement at the initiative of the Insured;
4) termination of the Agreement at the initiative of the Insurer;
5) in cases established by the legislation of the Republic of Kazakhstan or the Agreement.

15.2. In case of termination of the Agreement on the grounds specified in subparagraphs 1) - 5) of paragraph 15.1. of these Rules, insurance premiums paid to the Insurer are not refundable, unless otherwise provided for in the Agreement.

15.3. In case of refusal of the Insurant-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 received insurance premium(s) minus a part of the insurance premium(s) 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 received insurance premium (insurance contributions).

15.4. In case of refusal of the Insurant-individual from the Insurance Agreement related to the loan agreement, due to the fulfillment by him (the borrower) of obligations to the lender under the loan agreement, the Insurer shall be obliged to return to the Insurant-individual the received insurance premium(s) minus a part of the insurance premium(s) 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 premium (insurance premiums) received.

16. LIABILITY OF THE PARTIES

16.1. 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.

16.2. A party that has not fulfilled or improperly fulfilled its obligations under the 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.

16.3. 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 public authorities. A specific list of force majeure circumstances may be provided for in the Agreement.

16.4. 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 Agreement.

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

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

17. DISPUTE RESOLUTION PROCEDURE

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

17.2. 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, the insurance ombudsman is a mandatory stage of compliance with the pre-trial stage of dispute settlement. 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.

17.3. 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.

17.4. 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.

18. ADDITIONAL TERMS

18.1. These Rules shall come into force from the moment of approval by the Board of Directors.

18.2. Everything that is not stipulated by these Rules is regulated in accordance with the legislation of the Republic of Kazakhstan.

18.3. By agreement of the parties, special conditions (insurance clauses, definitions, exceptions, etc.) may be included in the concluded Contract, if they do not contradict the legislation of the Republic of Kazakhstan.