TRANSLATION FROM GERMAN ORIGINAL

GENERAL TERMS AND CONDITIONS OF MEDICAL EXPENSE AND DAILY HOSPITALIZATION BENEFIT INSURANCE

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In analogy to the wording of the (Austrian) Insurance Companies Supervision Act (*Versicherungsaufsichtsgesetz, VAG*), references to persons made in this text shall apply equally to both sexes.

CONTENTS

The General Terms and Conditions of Insurance are deemed to be part of the insurance contract, to the extent not provided otherwise in the Special Terms and Conditions of Insurance (*"STCI"*) (*Besondere Versicherungsbedingungen, BVB*) and/or the Tables of Benefits for the selected tariffs.

INSURANCE COVERAGE

Art 1 Subject and Scope of Insurance Coverage

(1) If an event insured against occurs, the insured shall be entitled to insurance coverage according to the selected tariffs.

(2) a) The event insured against is the medically necessary treatment of the insured on account of illness or in consequence of an accident. The event insured against commences upon treatment and ends when the necessity for treatment no longer exists according to medical findings. If the treatment has to be extended to an illness or to consequences of an accident bearing no causal link with the one(s) previously treated, this will be deemed a new event insured against.

b) The following are also deemed events insured against:

- for women insured at the adult premium the delivery, including the check-ups necessary on account of pregnancy, as well as the related medically necessary treatment, and
- any other events insured against that are provided in the STCI for the selected tariffs.

c) The following are not deemed events insured against:

- cosmetic treatments or surgical procedures and their consequences, unless such measures serve for removing consequences of an accident;

Cosmetic treatments within the meaning of the Terms and Conditions of Insurance do not serve for remedying a dysfunction of the body and thus for curing an illness that requires

treatment. The result of cosmetic treatment serves primarily aesthetic purposes. Corrective surgery after surgical treatment performed on account of overweight is therefore not deemed an event insured against even where the original surgical intervention was medically indicated in order to treat the overweight and was thus covered by the insurance.

- sex reassignment surgery and their consequences;
- tooth implantation or the measures or consequences causally connected thereto, unless they serve for removing consequences of an accident;
- prophylactic treatments and surgical interventions and their consequences;
- home care or geriatric, rehabilitative, orthopedagogic or logopedic measures or measures of medical gymnastics.
- inpatient stays which are due to age or to lack of home care

(3) Treatment is a medical treatment which according to the prevailing state of medical science is deemed to be likely to restore a person's health or to improve a person's condition or to impede a deterioration thereof.

(4) Illness is a physical or mental condition termed anomalous according to the prevailing state of medical science.

(5) Accident means any event independent from the will of the insured which suddenly occurs in the form of a mechanical or chemical impact from outside and results in bodily injury to the insured.

(6) Only persons in good health, domiciled in Austria and under 70 years of age are eligible for subscription. Any other persons can be enrolled under special terms and conditions. To the extent provided for by the respective tariff, dependents and partners of an insured living in the same household with the insured can be coinsured under special terms and conditions (premium rates) if they also meet the requirements of para 6 sentence 1.

Art 2 Conclusion of the Insurance Contract

(1) Unless agreed otherwise, only a person domiciled in Austria can be a policyholder or an insured.

(2) The applicant shall be bound by his/her application for six weeks. The period commences on the date of filing and/or dispatching the application.

(3) Acceptance of the application may also be made subject to the requirement of medical examination or the submission of a medical certificate. The costs shall be borne by the applicant.

(4) The management of the insurer shall decide whether to accept the application. The applicant must be informed of the decision in written form. The insurance contract will be deemed concluded upon delivery (handover) of the insurance certificate or of a declaration of acceptance issued in written form.

(5) Art 2 (5) Newborn children of any policyholders not entitled to benefits under statutory health insurance are entitled to insurance coverage pursuant to sec. 178e of the (Austrian) Insurance Contract Act (*Versicherungsvertragsgesetz*) to the same extent as applies to the policyholder; a corresponding request must be filed not later than two months after the child was born.

With respect to new-born children, the insurer waives its right of refusal (Art 2 para 4) and the exclusion from coverage set forth in Art 6 paragraphs 1 and 2, provided that:

a) the child's parents - and if there are already children also all children under the age of 18 living in the same household - have been insured for a period of at least three months under tariffs which correspond to the insurance coverage requested for the child; and

b) the coinsurance of the child is applied for within one month of birth with effect from the month of birth.

Art 3 Inception of Coverage

Insurance coverage shall commence upon conclusion of the insurance contract but not before the first premium has been paid, not before the qualifying periods have expired and not before the date specified in the insurance certificate (commencement of insurance).If the insurance certificate is handed over after this date but premium payment is then made within 14 days, insurance coverage shall commence on the date specified in the insurance certificate, subject, however, to any provisions on qualifying periods that may apply.

Art 4 Qualifying Periods

(1) The qualifying periods (as regards illness occurring during qualifying periods, see Art 6 paragraphs 3 and 4) are calculated as from the commencement of the insurance.

(2) The general qualifying period is three months.

It shall not apply in the event of:

a) accidents:

Intestinal or abdominal hernia and miscarriage or premature birth caused or aggravated by an accident are not deemed consequences of an accident;

b) the following acute infectious diseases: German measles, measles, chicken-pox (varicella), scarlet fever, diphtheria, pertussis, mumps, poliomyelitis, meningitis, dysentery, paratyphoid fever, spotted typhus (spotted fever), typhus, cholera, relapsing fever, malaria, anthrax, erysipelas, yellow fever, plague, tularemia, psittacosis;

c) coinsurance of spouse and new-born children for benefits up to the amount covered by the insurance in force

- if the insurance has been in force for at least three months; and
- if coinsurance is applied for within one month following the date of marriage or birth with effect from the first day of the respective month.

(3) Special qualifying periods apply to the following:

a) Deliveries, including the checkups necessary on account of pregnancy, as well as the related medically necessary treatment and any miscarriages shall be covered only after the expiration of a qualifying period of nine months unless it can be proved that the pregnancy in question occurred only after the conclusion of the insurance contract, during the period of coverage. If the husband, the common-law husband or the registered partner has at that time been insured for at least three months, such current insurance will be fully credited toward the qualifying period if the criteria according to para 2 c) are met.

b) To the extent that insurance coverage is specifically agreed for such illnesses or consequences of accidents as both contracting parties are already aware of at the time of concluding the contract, special qualifying periods may be agreed.

c) For additional special qualifying periods, if any, please refer to the STCI for the selected tariffs.

(4) The policyholder shall be entitled to transfer to a different tariff of the same type of insurance up to the current scope of coverage and be credited with the rights and old-age accruals acquired under the current term of the contract. When transferring to a higher tariff class, Art 2 shall apply analogously. A claim to higher insurance coverage shall exist only for such events insured against as occur after the new qualifying periods have expired.

(5) If proof is furnished that medical expense insurance is concluded within one month after the expiration of compulsory insurance and immediately following such compulsory insurance, the period of coverage of the latter will be credited towards the qualifying period; this shall also apply, analogously, to persons previously entitled to claim benefits from a social health insurance carrier. However, during the qualifying period inpatient treatment shall only be covered up to the amount of the benefit granted under the compulsory insurance. Deliveries and the consequences thereof shall only be covered after the expiration of the qualifying periods specified in para 3; the same shall apply in the event of check-ups necessary on account of pregnancy and any related medically necessary treatment, and in the event of miscarriages.

It must be proved to the insurer by appropriate documents that the requirements for the crediting of the period of coverage under the compulsory insurance have been met.

Art 5 Type and Extent of Insurance Coverage

(1) The type and extent of the insurance coverage provided are set forth in the tariff, the insurance certificate and any table of benefits that may be appended thereto. Insofar as benefits for outpatient and/or inpatient treatment are provided therein, the following provisions shall apply:

A. Benefits for Outpatient Treatment

(2) The insured may freely choose among the office-based physicians and dentists, the latter including so-called "Dentisten", admitted to independently practice their medical

profession. If medically necessary, the costs of the consultation of several physicians for a single event insured against will also be reimbursed.

(3) The costs of home visits by a physician will be reimbursed only if the condition of the insured does not permit a visit to the doctor; otherwise, only medical care in doctors' consulting rooms will be reimbursed.

(4) Traveling expenses of the physician will be reimbursed if there is no local physician at the domicile of the insured; expenses of the insured for traveling to the physician will not be reimbursed.

(5) cancelled

(6) Costs of diagnostic examinations (e.g. laboratory diagnostics, diagnostic imaging, ultrasound examinations) and costs of curative physiotherapy prescribed by a doctor will be reimbursed if performed by a doctor or a person authorized to provide treatment to patients.

Additional costs of medical care in doctors' consulting rooms or home visits are not covered in this context.

(7) Remedial devices (medical aids) are, e.g., spectacles, contact lenses, hernia trusses, artificial limbs, hearing aids, orthopedic corsets, orthopedic inserts and orthopedic adaptations of footwear, bandages and abdominal corsets, but not, e.g., irrigators, inhalers, breast pumps, oral irrigators, ice bags or packs, electric pads, clinical thermometers, blood pressure monitors or devices for correcting misalignment of teeth and/or jaws, or any other devices or appliances used for body care and nursing. If the insurer has reimbursed costs of remedial devices, a new claim for benefits will arise only after the expiration of the ordinary useful life of the device concerned, unless a new purchase is necessary for medical reasons at an earlier date.

(8) Costs of medication prescribed in the course of treatment and obtained from a pharmacy will be reimbursed.

Not reimbursed will be the costs of medicinal or mineral water, medicinal wine, nutriments or restoratives, food supplements, geriatric preparations, tonics, cosmetic agents or any medicines not registered in Austria.

B. Benefits for Inpatient Treatment

(9) Inpatient treatment within the meaning of these Terms and Conditions of Insurance is any treatment provided in the course of a medically necessary inpatient stay in hospitals or hospital wards approved by the public health authorities where permanent medical attendance is provided, where sufficient diagnostic and therapeutic means are available, that operate in accordance with the prevailing state of medical science, are not limited to certain specific treatments and keep case histories. A patient is deemed an inpatient only if the nature of the treatment requires a stay of at least 24 hours.

Inpatient stays for dental treatment and tooth replacements as well as for dental and oral surgery are deemed medically necessary only if outpatient treatment is impossible for medical reasons.

An inpatient stay will in particular not be deemed medically necessary if the hospitalization is only due to lack of home care or to other personal circumstances of the insured.

(10) Benefits for treatment provided in any of the hospitals that are specified below and/or in corresponding organizational units and forms of hospitals of whatever kind will be paid only to the extent these have been committed to by the insurer in written form prior to commencement of the treatment:

- those where, in addition to inpatient treatment, rehabilitative treatments or spa cures are also provided;
- those where long-term treatment (average duration of treatment exceeds 28 days) is provided;
- those that primarily perform measures of palliative care; and
- private hospitals outside Austria.

Coverage shall be approved if and to the extent that the insured has a claim under paragraph 9.

(11) No insurance coverage is provided in any of the hospitals that are specified below and/or in corresponding organizational units and forms of hospitals of whatever kind:

- those intended and equipped to provide care for those recovering and convalescent;
- for alcohol and drug addicts;
- sick wards of the Austrian Army;
- sick wards of prisons (prison hospitals);
- for mentally disturbed offenders;
- independently operating outpatient clinics (even if the examination or treatment to be performed requires a short-term stay);
- sanitariums, recreation and convalescent homes and homes providing dietetic services;
- geriatric facilities;
- hospice facilities;
- day and night hospitals.

Benefits shall only be provided up to the 14th day of treatment for each stay in hospitals and the corresponding organisational units and forms of health institutions for mental disorders or psychosomatic treatment, or in centres for mental health.

(12) The insurer may not claim exemption from liability under paragraphs 10 to the extent that and as long as the urgency of the inpatient treatment does not permit transferring to a hospital that meets the definition under para 9 and/or obtaining approval in written form according to para 10 prior to the commencement of the treatment.

(13) In case of medically necessary transport to and from a hospital for the purpose of undergoing an inpatient treatment covered by the insurance, the costs of transport by ambulance, up to the amount specified in the table of benefits, shall be reimbursed per stay in hospital.

(14) The insurer shall be notified of the hospitalization for inpatient treatment by submission of a medical certificate where the illness must be named, if possible prior to admission and, in urgent cases, as soon as possible after admission to the hospital.

C. Common Provisions

(15) Costs of the surgical procedure means the fees of the surgeon, of the anesthetist and of the physicians assisting in the surgical procedure and the costs of the nursing staff for the surgical procedure including pre- and post-operative treatment. The related costs of materials, such as, e.g. the costs of artificial parts of the body, implants and other therapeutic devices such as, in particular, any apparatus that replaces an organ or supports its function, shall not be separately reimbursed. Several surgical procedures performed at the same time shall be compensated according to the provisions contained in the STCI and/or the table of benefits.

(16) Costs of other treatments shall mean the fees of the attending physician and his/her assistant(s), the costs for the use of equipment and for radiant and other material as well as all ancillary costs. ´

(17) Only such costs of inpatient and outpatient treatment as are reasonable and customary in the relevant place shall be refunded by the insurer.

(18) If treatment is provided by the spouse, partner, partner in a registered partnership, parents or children, step-parents or step-children, or parents in law or sons or daughters in law of the insured, only the documented costs of materials will be reimbursed.

D. Special Provision

(19) Benefits payable for deliveries and for examinations necessary due to pregnancy shall be the same as for treatment due to illness.

Art 6 Limitation of Insurance Coverage (See also Art 1 para 2 sub-para c)

(1) Treatment which started prior to the commencement of insurance shall not be covered.

(2) Illnesses and consequences of accidents that although beginning or occurring prior to the commencement of insurance do not result in treatment until thereafter shall be included in the insurance coverage only subject to the provisions of Art 11 and Art 6 para 6.

After the end of three years following the conclusion of the contract, the insurer may no longer invoke the provisions of Art 11, unless the duty of disclosure was violated with fraudulent intent.

(3) Illnesses and consequences of accidents first treated during the qualifying period (Art 4) are exempt from coverage until the end of the event insured against, but at the most for a period of three years after the conclusion, modification or reinstatement of the insurance contract; the same shall apply to any illnesses which are directly causally linked with the foregoing. The insurer shall be liable only if the policyholder proves that the illness became apparent only after the conclusion of the contract.

(4) Illnesses and consequences of accidents according to paragraphs 1 to 3 can be included in the insurance coverage on special conditions (higher premium, special qualifying periods).

(5) Not covered are treatments:

- of illnesses or accidents arising out of the abuse of alcohol or addictive drugs, or withdrawal measures or treatments;
- in case of commitment for causing danger to the insured him/herself or to others;
- of illnesses or accidents or the consequences thereof arising out of active participation in riots, culpable participation in brawls, or when committing an offense which requires intent;
- of the consequences of attempted suicide;
- of illnesses or accidents or the consequences thereof if intentionally caused by the insured; if the policyholder has intentionally caused or contributed to the illness or the accident of an insured, the insurer shall remain liable vis-à-vis the insured. The damage claim of the insured shall, however, pass on to the insurer (sec. 67 of the Insurance Contract Act);
- of the consequences of accidents occurring during participation in federal or international sports competitions or in the official training for such events;
- of illnesses or accidents or the consequences thereof arising out of warlike events, including any kind of acts violating neutrality.

(6) The treatment of illnesses and consequences of accidents disclosed by the policyholder and/or the insured prior to the conclusion of the insurance contract may be excluded from coverage only by an express statement in written form issued by the insurer.

(7) If the treatment exceeds the normal requirements, the insurer shall be entitled to reduce the benefits to the reasonable extent.

(8) Insofar as the amount of costs is governed by statutory provisions or contractual agreements with the insurer, the insurer cannot be held liable for the reimbursement of any costs exceeding such amount (e.g. special fees of the heads of university hospitals according to sec. 46 of the (Austrian) Hospitals and Sanatoria Act (*Krankenanstalten- und Kuranstaltengesetz, KAKuG*) and the implementing legislation enacted by the Federal Provinces).

(9) Upon good cause shown, the insurer may exclude from coverage the treatment by special physicians or dentists, the latter including so-called "Dentisten", or the treatment in special hospitals and/or in corresponding organizational units and forms of hospitals of whatever kind. This shall apply to treatments provided after delivery of the notice of refusal of coverage. Current events insured against shall be covered until the end of the third month that follows delivery of the notice.

Art 7 Payment of Insurance Benefits

(1) Benefits of the insurer shall be due upon termination of the inquiries and investigations necessary to determine the event insured against and the amount of the benefit payable by the insurer. But regardless thereof the benefit shall become due and payable if the policyholder, after the expiration of two months as from his/her notice of the event insured against, requests a declaration by the insurer as to why the inquiries and investigations have not yet been finalized and the insurer fails to comply with such request within one month.

(2) Benefits shall be paid out on the basis of original invoices where receipt of the money has been duly confirmed, or hospitalization certificates. These documents must show the first name and surname, the address, the policy number and the date of birth of the person under treatment and specify the illness and the services performed and the dates of treatment.

If the insured is covered under yet another (statutory or private) health insurance, duplicates of the above documents, including the relevant statement of account, or detailed statements of account of the other insurers may also be submitted.

In the event of a home delivery, payment of the benefit shall be subject to the submission of a birth certificate issued by the Office of Vital Statistics.

(3) The insurer is entitled to regard the person delivering the documents as having the right to receive the respective insurance benefits.

(4) The documents shall become the property of the insurer.

(5) The costs of the remittance of the benefit as well as the costs of translations shall be borne by the policyholder.

(6) For treatments outside Austria, all provisions contained in these General Terms and Conditions of Insurance concerning the use of services rendered by Austrian physicians and dentists (including so-called "Dentisten") and by Austrian health facilities shall apply analogously. Payments for benefits are made in Austria in euros. The exchange rate shall be the mean rate of exchange quoted by the Vienna Stock Exchange on the last day of treatment.

(7) The claims to insurance benefits cannot be pledged or assigned, except with the consent of the insurer. The policyholder shall be entitled to offset his/her claims against claims of the insurer only if his/her claims are counterclaims which are legally related to the insurer's claim and have been established by a court or acknowledged by the insurer.

(8) The insurer shall be exempt from its liability if the claim to the benefit is not enforced by legal action within a period of one year. The period shall commence only after the insurer has notified the policyholder in written form of the refusal of the claim filed, stating the legal consequences of the expiration of the period.

(9) Claims to insurance benefits become statute-barred after three years. Where a claim has been filed with the insurer, the running of the period of limitation shall be suspended until a decision by the insurer in written form has been received which must be substantiated at least by one of the facts and one of the statutory or contractual provisions justifying the refusal of the claim. The claim shall become statute-barred after 10 years at any rate.

Art 8 Suspension of Insurance Coverage

(1) On the policyholder's request it may be agreed upon in well-founded cases that the rights and duties under the insurance contract shall be suspended for a period set in advance but not exceeding twelve months.

(2) Events insured against that occur during the suspension of the insurance contract shall not be covered. If treatment continues after the end of the suspension period, insurance coverage shall commence as of the end of the suspension period. In regard to the suspension period, a suspension charge of 10% of the premium shall be paid for the agreed suspension period in advance. Reinstatement of the insurance contract prior to the expiration of the period agreed upon may be made conditional on a medical examination.

Art 9 Termination of Insurance Coverage

Insurance coverage shall end upon termination of the insurance contract. This shall also apply to events insured against which occurred before, or were current at, termination.

DUTIES OF THE POLICYHOLDER

Art 10

A. Premiums, Fees and Charges

(1) The premium is an annual premium and is computed as from commencement of the insurance. It shall be paid at the beginning of each insurance year but may also be paid in equal monthly installments, with each such installment being deemed deferred until its due date. The premium installments shall be due on the first day of each month. The first premium plus incidental fees shall be due upon handing over and/or offering the insurance certificate, at the latest.

(2) The age of subscription is defined as the difference between the year the insurance commences and the year of birth.

(3) cancelled

(4) If a child has reached the age of 20, the premiums applicable to adults shall be paid as from the first day of month in which the child reaches the age of 20.

(5) If more than three siblings under the age of 20 are coinsured under one insurance certificate, the premium shall be paid for three children only.

(6) The premiums shall be paid to the agency to be designated by the insurer.

(7) If any additional expenses are occasioned by the policyholder, fees may be charged in respect thereof.

B. Default in Payment and Consequences Thereof

(8) If the first premium or the first premium installment is not paid within fourteen days after the conclusion of the insurance contract and after a request to pay the premium, the insurer may withdraw from the insurance contract, as long as the payment has not been effected. If the claim to the premium is not enforced by legal action within three months of the due date, the insurer will be deemed to have withdrawn from the contract.

If the premium has not been paid at the date of the occurrence of the event insured against nor after the expiration of the fourteen-day period, the insurer shall be exempt from its liability, subject to the provisions of sections 38 and 39a of the Insurance Contract Act, unless the policyholder was prevented from timely paying the premium without any fault on his/her part.

(9) If, subsequently, a premium or premium installment due is not paid in due time, the insurer may request the policyholder in writing, by indicating the outstanding amount of premium and expenses as well as the legal consequences of further delay, to pay the debt to the agency designated by the insurer without deducting any remittance fees within a period of at least two weeks following receipt of the request for payment.

In addition to postage and costs incurred in requesting payment, default interest at the statutory rate fixed for default interest may be collected. If the premium requested in the reminder has not been paid at the expiration of the term of payment, all deferred premium installments of the current insurance year shall fall due for immediate payment.

(10) If the event insured against occurs after the term of payment has expired and if the policyholder is in default with the payment of all or a portion of the premiums at such time, the insurer shall be exempt from its liability, subject to the provisions of sections 39 and 39a of the Insurance Contract Act, unless the policyholder was prevented from timely paying the premium without any fault on his/her part. The insurer's liability shall revive after payment of all outstanding premiums; however, events insured against which occur after the expiration of the term of payment and before payment of the outstanding premiums, or the consequences of such events, shall not be covered.

(11) The insurer may cancel the insurance contract without observing a notice period if the policyholder is in default with payment after the expiration of the term of payment. Already when setting the term of payment, the insurer may provide the cancellation of the insurance by stating that the cancellation shall be effective as of the date of the expiration of the term of payment if the policyholder is in default with payment at that time.

(12) The consequences of the cancellation shall not come to bear if the policyholder effects the payment within one month of cancellation or, where cancellation has been connected to the setting of the term of payment, within one month of the expiration of the term of payment.

(13) Any premium payments received shall be applied to the oldest amount of premium outstanding.

Art 11 Obligations

A. Duty of Disclosure Prior to the Conclusion of the Insurance Contract

(1) At the time of filing the application, and in the period between the filing of the application and the delivery (handing over) of the insurance certificate, the policyholder and the insured shall disclose all relevant hazards, i.e. all circumstances relevant for the assumption of the risk. In case of doubt, any hazard explicitly inquired after by the insurer in written form will be deemed relevant.

B. Consequences of Violating the Duty of Disclosure Prior to the Conclusion of the Insurance Contract (see also Art 6)

(2) In the event that the policyholder or an insured has violated the duty to disclose relevant hazards, i.e. circumstances relevant for the assumption of the risk, the insurer may withdraw from the insurance contract. This shall also apply where disclosure of a relevant hazard was omitted because the policyholder / the insured evaded gaining knowledge of the hazard with fraudulent intent. The duty of disclosure will also be deemed violated if questions regarding hazards are answered incompletely or incorrectly.

(3) The insurer may withdraw from the insurance contract within one month from the date when the insurer has learned that the duty of disclosure has been violated.

There is no right of withdrawal where the insurer had knowledge of the hazard not (fully) disclosed or incorrectly disclosed. There shall also be no right of withdrawal where the violation of the duty of disclosure occurred without any fault on the part of the policyholder / the insured; however, where the policyholder / the insured failed to disclose a hazard not inquired after by the insurer explicitly and in specific terms, the insurer may only withdraw from the insurance contract if disclosure was omitted willfully or by gross negligence. Where the policyholder / the insured was required to disclose the hazards by answering questions which were put in written form by the insurer, the insurer may only withdraw from the contract on the grounds of failure to disclose a hazard not inquired after explicitly and in specific terms in the event of fraudulent concealment. If the insurance contract is concluded by a representative or an agent acting without authority, not only the knowledge and fraudulent intent of the agent but also the knowledge and fraudulent intent of the policyholder / the insured are of relevance to the insurer's right of withdrawal. The policyholder / the insured can only plead that disclosure of a relevant hazard was omitted or incorrectly made without fault if neither the agent nor the policyholder / the insured was at fault.

(4) Where the insurer withdraws from the insurance contract after an event insured against has occurred, coverage shall continue if the hazard which was not disclosed in violation of the duty of disclosure did not influence the occurrence of the event insured against or the extent of the insurance benefit. However, insurance coverage shall under no circumstances apply to the period after the withdrawal. The insurer may claim repayment, in full or in part, of any benefits which are related to facts which have resulted in the withdrawal.

(5) In case of withdrawal, the insurer is entitled to the premium until the end of the current month of insurance.

(6) If the conditions justifying the withdrawal apply only to some of the persons insured, withdrawal can be limited to these persons. In this case the policyholder shall be entitled to

cancel the insurance contract in its entirety with immediate effect within one month of receiving the notice of withdrawal.

(7) The right of the insurer to avoid the insurance contract due to fraudulent intent shall not be affected by the above provisions.

(8) Where the duty of disclosure has been violated without fault, the insurer shall be entitled to charge the correspondingly higher premium as from the beginning of the current policy year if the business plan provides a higher premium where the hazards previously unknown to the insurer are present. This shall also apply where a hazard relevant for the assumption of the risk was not disclosed to the insurer when concluding the insurance contract because the other party had no knowledge of such hazard. If according to the principles governing the business plan of the insurer such higher risk is not assumed even in return for a higher premium, the insurer may cancel the insurance observing a notice period of one month. The right to the higher premium shall lapse if not asserted within one month of the time the insurer gains knowledge of the violation of the duty of disclosure or of the hazard not disclosed. This shall also apply to the right of cancellation if not exercised within the designated period.

C. Duties of the Policyholder and the Insured During the Existence of the Insurance Contract

(9) Upon request of the insurer, the policyholder and the insured shall furnish the insurer with any information necessary for ascertaining the event insured against or the type and extent of insurance coverage.

This shall include, among other things:

- the obligation of the insured to undergo examination by a physician commissioned by the insurer if the insurer so requests; and
- the obligation of the policyholder and/or the insured to provide the insurer with the documents requested by it; and
- if this has not already been done in the application - releasing third parties (e.g. physicians, insurance facilities, authorities) from their medical or other professional secrecy obligation.

(10) If health insurance is taken out for an insured with another insurance company, the insurer shall be notified of the additional insurance contract without delay.

D. Consequences of the Violation of Duties During the Existence of the Insurance Contract

(11) If the policyholder or the insured violates the duty of disclosure provided for in Art 11 para 9, the insurer shall be exempt from its liability. However, this shall not apply if the violation is not the result of willful intent or gross negligence.

If the obligation is not violated with the intention to influence the insurer's liability or hinder the determination of circumstances which can reasonably be expected to be of relevance to the insurer’s liability, the insurer shall remain liable insofar as the violation has influenced neither

the determination of the event insured against nor the determination or the extent of the insurer's liability.

(12) If the duty to furnish information as mentioned in Art 11 para 10 is violated, the insurer shall be exempt from the obligation to pay benefits granted as lump-sum amounts, e.g. daily hospitalization benefit, substitute daily hospitalization benefit, sickness benefit or cure allowances. Moreover, the insurer may cancel the insurance contract, without observing a notice period, within one month after it has learned of the violation of the duty to furnish information. If the insurer does not cancel the insurance contract within one month, it may not plead exemption from its liability. There shall be no exemption from liability and no right to cancel the contract where the violation must be deemed not to have been culpably committed.

(13) The insurer can only derive rights from a violation of an agreed obligation committed by a negligent act or omission if the policyholder received the Terms and Conditions of Insurance or any other document informing him/her of the obligation beforehand.

Art 12 Claims against Third Parties

(1) Where, in addition to the claim against the insurer, there are similar claims against third persons or insurance carriers under public law or private insurance carriers in respect of an event insured against, such claims shall be assigned to the insurer insofar as it reimburses the costs. The beneficiary is obligated to confirm this assignment to the insurer in writing upon request.

(2) To the extent that the beneficiary has already been reimbursed for his/her costs by third persons liable for compensation or under other insurance contracts, the insurer shall be entitled to deduct such reimbursement from its benefits.

(3) Paragraphs 1 and 2 shall not apply to benefits for which no proof of costs needs to be furnished.

(4) The obligation of the insurer to reimburse costs which the beneficiary may claim, in part, from an insurance carrier under public law shall only arise after the benefits due from the latter have been granted.

(5) If the beneficiary waives his/her claim against third parties or a right serving as security for the claim without the insurer’s consent, the insurer shall be exempt from its liability insofar as it could have obtained compensation out of the claim or the right.

TERMINATION OF THE INSURANCE CONTRACT

Art 13 Cancellation by the Policyholder

(1) The insurance contract is concluded for an unspecified period of time. The policyholder shall have the right to cancel the insurance contract as of the end of any insurance year, but

not with effect before the expiration of any contract period agreed upon, subject to a notice period of three months.

(2) The insurance year shall depend on the original commencement of the insurance.

(3) Notice of cancellation shall be given in writing and should be addressed to the Management of the insurer.

(4) If the policyholder cancels the insurance contract in regard to individual persons insured, the insurer shall be entitled, within a period of one month, to cancel the insurance contract in regard to the remaining persons insured as of the same effective date. The insurance policyholder has the right to withdraw the original notice of termination within one month after the insurance company has also issued a notice of termination.

(5) If a policyholder or an insured is admitted to a nursing home for the chronically ill, the policyholder shall be entitled to cancel the insurance contract as of the end of the month in which the policyholder furnishes proof of admission to such an institution.

Art 14 Unilateral Termination of Contract by the Insurer

(1) A right of the insurer to unilaterally terminate the insurance contract shall only exist in the following cases:

- default in premium payment as described in Art 10 paragraphs 8 and 9;
- violation of an obligation provided for in Art 11;
- as a consequence of a cancellation by the policyholder as described in Art 13 para 4;
- culpable conduct on the part of the policyholder or the insured as described in para 2 below.

If premiums in accordance with § 11 (8) are increased, the policyholder has the right to terminate the insurance contract with respect to the persons concerned within one month from the receipt of notification about the change from the effective date of the change.

(2) If the policyholder or an insured surreptitiously obtains, or attempts to surreptitiously obtain, insurance benefits by fraudulent misrepresentation, in particular by feigning an illness, or participates in any of the above, the insurer shall be exempt from its liability and shall further be entitled to cancel the insurance contract without observing a notice period, within one month after it has gained knowledge of the violation. The same shall apply if, in the event of illness, the insured, either willfully or by gross negligence, does not comply with the reasonable rules of conduct prescribed by the physician or the insurer. Where rules of conduct that can reasonably be expected to be complied with have been violated, the insurer shall not be able to plead exemption from liability and/or a right of cancellation if the violation had no influence on the occurrence of the event insured against.

Art 11 para 13 shall apply analogously.

(3) If the insurer cancels the insurance contract in regard to individual persons insured, the policyholder shall be entitled to cancel the insurance contract in regard to the remaining persons insured within a period of one month, as of the same effective date.

Art 15 Other Grounds for Termination

(1) The insurance contract shall terminate upon the death of the policyholder. However, the persons insured shall be entitled to continue the insurance contract by designating the future policyholder. The declaration shall be submitted within two months of the death of the policyholder.

(2) Upon the death of an insured, the insurance contract shall terminate in regard to this person.

(3) The insurance contract shall also terminate upon the transfer abroad of the policyholder's or the insured's domicile, unless agreed otherwise. The insured's residence shall be the place where the insured has taken up residence with the proven intention, or where such intention is clear from the circumstances, of making that place his/her permanent residence. The provisions of para 1 shall apply analogously.

MISCELLANEOUS

Art 16 Form and Recipient of Declarations of Intention and Notifications

(1) Any and all notifications and declarations addressed by the policyholder to the insurer require the written form (*geschriebene Form*) unless it has been expressly agreed by separate declaration that they have to be made in writing (*Schriftform*). The written form will be deemed complied with if a text in alphabetic characters is received from which the person making the declaration can be identified (e.g. telefax or e-mail). "In writing" shall mean that the recipient of the declaration must receive the original of the declaration, which must bear the personal signature of the person making the declaration. The qualified electronic signature in accordance with sec. 4 of the (Austrian) Electronic Signature Act (*Signatur-gesetz*) is not accorded the same status as the personal signature.

(2) If the policyholder has changed his/her address without notifying the insurer thereof, the sending of a letter to the address last notified to the insurer shall be sufficient for declarations made by the insurer to the policyholder to have legal effect. The declaration shall be effective as of the time it would have been received by the policyholder upon regular carriage if there had been no change of address. If electronic communication has been agreed, this shall only apply if the insurer notified the policyholder electronically in due time (provided that electronic notification was possible) that a letter was being sent and of the above-mentioned consequences of omitting to notify a change of address. This shall apply analogously for declarations made to an insured.

Art 17 Place of Performance

The place of performance for the mutual obligations under the insurance contract shall be the seat of the insurer.

Art 18 Change of Premium or of Insurance Coverage (Adjustment)

(1) Any change in the circumstances set forth below will be deemed a circumstance relevant for changes to premium or insurance coverage within the meaning of sec. 178f of the Insurance Contract Act:

- the average life expectancy
- the frequency with which benefits of the kind provided for in the contract are claimed and their amounts as compared to the persons insured under this tariff;
- the ratio between the contractually agreed benefits and the corresponding cost refunds by the statutory social security carriers;
- the consideration payable for the utilization of health care facilities specified in the insurance contract, as fixed by the law, by regulation, or by other government measure or by a contract between the insurer and the respective health care facility; in fixing the amount of the adjustment, however, charges and/or fees on the amount of which no agreement could be reached with the insurer shall not be taken into consideration; if this applies to the charges and/or fees of all the hospitals in the respective federal province, the adjustment shall be made on the basis of the fluctuation of the consumer price index as published by the Austrian Central Statistical Office from time to time. If the consumer price index is no longer published, the values replacing it shall be applicable; if the computation of the consumer price index is changed fundamentally, the insurance supervisory authority shall specify the reference value applicable then;
- the health system or the statutory provisions governing it.

(2) Any notice of a change of the premium or insurance coverage with retroactive effect shall be invalid; the change shall enter into effect only as from the first day of the month following dispatch of the notice.

(3) On the date of the adjustment, the premiums, benefits and amount of any deductibles change according to the new benefit and premium overview. For the calculation of the partial premium for the changed benefits, the age at the time of the adjustment is authoritative

(4) In the event of an adjustment, the provisions of Art 4 para 4 of the GTCI and of Art 6 paragraphs 1 and 2 of the GTCI shall not be applicable.

(5) If the insurer increases the premium, the insurer must, upon request by the policyholder, offer to continue the policy at a premium that is no larger than the previous premium, with appropriately modified benefits. The insurer shall expressly inform the policyholder about this right once again in the notification about the premium increase.