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Allianz

Supplementary insurance for Allianz Myhome insurance

Customer information and General Terms and Conditions

AHE-12719/1A

Effective from 25 August 2026

Information about your supplementary insurance

These general terms and conditions contain the provisions applicable to the following supplementary insurance policies concluded between Allianz Hungária Zrt. (hereinafter: insurer) and the policyholder in connection with the Allianz MyHome insurance policy (hereinafter: basic insurance) Supplementary family accident insurance, Supplementary Family Life Insurance, Supplementary health insurance for high-value diagnostic care, Supplementary Legal Protection Insurance and Supplementary Medical Call Centre Services, provided that the cover was taken out with reference to these terms and conditions.

The main details of the insurer, the provisions of the applicable law, information relating to the sale of insurance products (advice, remuneration), the provisions of the insurance contract relating to the processing of personal data, the rules relating to insurance secrecy, information on complaint handling, information on distance selling, and the rules governing electronic contracting are set out in a separate document („Supplement to the Data Management and Customer Information and General Terms and Conditions") supplementing this Customer Information and General Terms and Conditions. For matters not covered in these Supplementary Terms and Conditions, the terms and conditions of the Allianz MyHome Insurance shall apply. These Supplementary Terms and Conditions may be concluded together or separately, depending on the choice of the contracting party.

In the event of any discrepancies between these terms and conditions and the General Terms and Conditions of Allianz MyHome Insurance and the Special Terms and Conditions of Property Insurance Coverage, these terms and conditions will prevail. In matters not regulated by these Supplementary Terms and Conditions or the General and Special Terms and Conditions of Allianz MyHome Insurance, Act V of 2013 on the Civil Code (hereinafter referred to as the Civil Code) Act LXXXVIII of 2014 on Insurance Activities (Bit.) and the provisions of the Hungarian legislation in force shall apply.

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Supplementary family accident insurance

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1. Contracting party, insured party, beneficiary

Contracting party
For the purposes of this supplementary insurance, the policyholder is the same as the policyholder of the basic insurance, Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, point 1.

Insured
The insured is the same as the insured under the Basic Insurance, the natural person insured specified in Section 1 of the Allianz MyHome Insurance Benefits Guide, II. Special Insurance Terms and Conditions of Property Insurance, point 1.

Beneficiary
The beneficiary is the person who is entitled to insurance benefits in the event of accidental death.

The beneficiary of the death benefit shall be the insured person's heir, unless otherwise specified or if the designation of the beneficiary was not valid at the time of the insured event.

The policyholder may designate the beneficiary by means of a written statement addressed to the insurer and delivered to the insurer. If more than one beneficiary is designated, the proportion of the benefit must be specified. In the absence of such specification, the proportion of the benefit shall be deemed to be equal.

The policyholder may designate another beneficiary in place of any beneficiary by means of a written statement addressed to the insurer and delivered to the insurer before the occurrence of the insured event. The policyholder may revoke the designation at any time in the same form or designate another beneficiary in place of the designated beneficiary.

The written consent of the insured person is required for the designation or change of the beneficiary, unless the insured person is the policyholder. Any provision in a contract concluded without the consent of the insured person designating a beneficiary shall be null and void. In such cases, the insured person or his/her heir shall be considered the beneficiary, who shall be obliged to reimburse the policyholder for the premiums paid and the costs incurred in connection with the contract.

The policyholder may undertake, by means of a written statement addressed to the insured and/or beneficiary, to keep the designation of the beneficiary in force. The policyholder shall inform the insurer of the statement. Such beneficiary designation may not be changed or revoked without the consent of the insured and/or beneficiary.

The designation of the beneficiary shall cease to be effective if the beneficiary dies before the occurrence of the insured event or if the legal entity beneficiary ceases to exist without a legal successor. If the policyholder does not make a new declaration of beneficiary in such a case, but has previously designated several beneficiaries, the ratio of the remaining designations to each other shall determine the ratio of the beneficiaries.

2. Territorial and temporal scope

The supplementary insurance covers insured events occurring anywhere in the world during the risk coverage period of the basic insurance, after the commencement of the risk coverage of the supplementary insurance. If the policyholder takes out supplementary insurance at a later date, the insurer shall bear the risk from the date of validity of the contract amendment as stated in the policy.

3. Conclusion of supplementary insurance

3.1. This supplementary insurance is linked to the Basic Insurance and, in this respect, can only be taken out under the Basic Insurance contract, either at the same time as the Basic Insurance is taken out or after the Basic Insurance has been taken out.

3.2. If the supplementary insurance is concluded after the conclusion of the Basic Insurance, the date of conclusion of the supplementary insurance shall be the day following the receipt of the declaration of conclusion by the insurer.

4. Inception date of the supplementary insurance

With regard to this supplementary insurance, the commencement of risk coverage:
- coincides with the commencement of risk coverage under the Basic Insurance, if it was concluded at the same time as the Basic Insurance contract,
- the date specified in the declaration concerning the conclusion of the supplementary insurance, or, in the absence thereof, 00:00 hours on the day following the receipt of the declaration by the insurer, if this supplementary insurance is concluded subsequently to an existing Basic Insurance contract.

5. Duration of the supplementary insurance

The supplementary insurance is of indefinite duration.

6. Modification of the supplementary insurance

The provisions governing the modification of the supplementary insurance are contained in the Allianz

MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 5.

7. Termination of supplementary insurance

7.1. Upon termination of the Basic Insurance, all elements of the supplementary insurance shall also terminate.

7.2. The policyholder may terminate this supplementary insurance at any time in writing, while the basic insurance remains in force. The date of termination shall be the date specified by the policyholder in the notice of termination of the supplementary insurance, or, in the absence thereof, the day following the date of receipt of the notice by the insurer.

7.3. Further provisions regarding the termination of supplementary insurance due to loss of interest or impossibility are contained in Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 6.

8. The premium for supplementary insurance

The insurance premium must be paid in Hungarian forints together with the Basic Insurance premium and according to the same payment frequency as the Basic Insurance. If the supplementary insurance is taken out after the Basic Insurance has been concluded, the first premium for the supplementary insurance shall be determined in accordance with the provisions of Section 7.3.2 of the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions.

9. Sum insured of the supplementary insurance

9.1. The initial sum insured under the supplementary insurance is determined by the policyholder.

9.2. The initial minimum sum insured for supplementary insurance is HUF 200,000, which can be multiplied up to HUF 2,000,000 in increments of HUF 200,000.

10. Rules for indexation

The sum insured and premium for supplementary insurance shall change in proportion to the indexation of the sums insured and premiums for basic insurance. The rules governing indexation are set out in the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 9.

11. Deductibles

The insurer shall not deduct any excess if it provides benefits under the supplementary family accident insurance.

12. Obligations of the insured person and beneficiary

12.1. **Obligation to notify and report changes**
The rules governing the obligation to notify and report changes are set out in Allianz MyHome Insurance Benefits Guide I. General Insurance Terms and Conditions, Section 11. A. b), with the additions set out in Sections 12.2 and 12.3 below.

12.2. If the information provided in response to the insurer's questions proves to be untrue (breach of the notification obligation), the insurer shall not be obliged to pay
a) with regard to the insurance cover.
b) when increasing the sum insured, the difference between the sum insured before and after the increase.

12.3. The insurer's payment obligation arises
a) in relation to the insurance coverage,
b) when increasing the sum insured, in relation to the difference between the sums insured before and after the increase,
if it is proven that the insurer was aware of the concealed or unreported circumstance at the time the insurance cover was established, or when the sum insured was increased, or when the duration of the insurance cover was extended, or that it did not contribute to the occurrence of the insured event.

12.4. **Obligation to report damage (report an insured event)**
The insured event must be reported to the insurer within 30 working days of its occurrence. Further rules relating to the reporting of claims are set out in the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions 11. A., d).

12.5. **Documents required for reporting a claim (for the provision of services)**
The following documents must be submitted to the insurer to confirm the occurrence of the insured event and to determine the extent of the service to be provided:

A. Documents certifying the occurrence of the death
- a copy of the death certificate,
- a copy of the medical or official certificate (post-mortem certificate) certifying the cause of death.

B. Personal identification data
a) Documents, certificates and data certifying the identity of the natural person entitled to claim the benefit or the legal entity, such as
   - for natural persons: identity card or passport or card-format driving licence, as well as an official document certifying their address, plus tax identification document,

  - e.g. tax card or, in the case of natural persons who are not Hungarian tax residents and do not have a Hungarian tax identification number, a copy of a document containing the tax identification number of the country of tax residence,
  - in the case of a legal entity: a company extract not older than 30 days containing the company registration number or registration number and tax number, and tax identification document, and in the case of a legal entity without Hungarian tax jurisdiction and without a Hungarian tax number, a copy of a certificate of residence issued by the tax authority of the country of tax residence, not older than 30 days,

b) documents certifying the procedural authority of the natural person acting on behalf of the legal entity entitled to use the service.

C. Official documents

- any official proceedings initiated in connection with the reported insured event, minutes of on-site inspections, expert opinions, minutes of hearings, official notifications and certificates issued during the investigation,
- the final decision concluding the administrative proceedings initiated in relation to the reported insured event has been issued,
- official documents relating to the traffic accident (valid driving licence of the insured driver or in the absence of a driving licence, an official certificate issued by the competent ministry authorised to issue driving licences, registration certificate),
- if the insured person's heir is entitled to the service, a final notarial or court decision on inheritance or a copy of the certificate of inheritance,
- if the person entitled to the payment is a minor, proof of the legal representative's authority to act on their behalf,
- if the person entitled to the payment is under guardianship, a decision of the guardianship authority certifying the identity of the guardian acting on his or her behalf,
- if required by separate legislation, permission from the guardianship authority for the payment.

D. Medical documents

- copies of GP records and treatment records, copies of specialist and hospital treatment documents,
- certificates issued by the National Health Insurance Fund (NEAK) and its legal predecessors, as well as data processed by it, health documents available on the Electronic Health Service Space (EESZT) interface,
- in the event of damage to health, medical documents certifying this, i.e. all medical documents prepared prior to the notification of damage to health and all medical documents prepared after the date of the accident,
- the post-mortem report,
- documents certifying hospitalisation, copies of final reports and outpatient treatment records,
- document certifying incapacity to work,
- a copy of the autopsy report,
- official confirmation of the results of alcohol consumption tests,
- official medical documents or official decisions concerning the effects of narcotics or other intoxicating substances,
- documents relating to medical diagnostic procedures (e.g. X-rays, MRI, CT scans),
- medical or official confirmation of burn injuries (fire brigade report),
- copies of all documents related to medical treatment.

E. Documents related to the insurance contract

- detailed report describing the insured event,
- power of attorney in the case of authorised representation,
- in the case of taxable insurance services, documents necessary for determining the amount of tax to be deducted by the insurer.

F. Additional documents required for payment

- identification data sheet,
- declaration of beneficial ownership,
- declaration of prominent public figures, close relatives of prominent public figures, or persons in a close relationship with them,
- declaration of tax residency,
- payment transfer order,
- in the case of persons residing abroad, a declaration of residence abroad, and
- in the case of non-Hungarian tax residency, the foreign tax identification number and a certified copy of the certificate containing it (a bilingual certificate issued by the tax or other authority of the country of tax residency – CERTIFICATE OF RESIDENCY – containing the tax identification number of that country).
- In the event of sanctions, a statement regarding the sanctions.

G) Additional documents required for payment to heirs

The documents specified in the section entitled „Processing of personal data" in the document entitled „Data Processing and Customer Information Supplement to the General Terms and Conditions and Customer Information", in connection with the processing of the heirs' data.

In the event of an insured event occurring abroad, the insurer may request the presentation of a certified translation of the documents into Hungarian, prepared at the expense of the beneficiary.

The insurer is not obliged to return the documents submitted for the assessment of entitlement to the service unless the insured expressly requests this.

In addition to the items listed in points A-G) above, the insured person is also entitled to prove the insured event in other ways in accordance with the general rules of evidence.

12.6. The insurer shall be entitled to verify the content of the medical documents submitted in connection with the occurrence of the insured event and to review the insured person's health condition, the necessity of medical procedures and the duration of treatment. The insured acknowledges that the review of their health condition may include an examination by the insurer's doctor.

12.7. In individual cases, the insurer may also request the opinion of an independent medical expert. The insured person undertakes to undergo the examination carried out by the insurer.

12.8. The insurer shall process and store the findings of medical examinations conducted by it, as well as documents related to the insurance and received or prepared during the settlement of claims, in accordance with the rules governing data processing.

13. Insurance events

1. Table

	Insured event	Service
	Accidental death	100%ofthe sum insured
Permanent health impairment	Accidental permanent health impairment of 25-100%	Percentage of the sum insured specified in Table 2 Percentage
	Permanent health impairment of 10-24% caused by an accident	Percentage of the sum insured corresponding to the degree of permanent health impairment
Temporary health impairment	Five days (continuous) or more, accident-related, inpatient hospital treatment	3%ofthe insured amount
	Bone fracture	3%ofthe sum insured

13.1. Definition of accident: For the purposes of these terms and conditions, an accident is defined as a sudden external impact beyond the control of the insured person, as a result of which the insured person
a) suffers a temporary injury, or
b) dies within one year at the latest, or
c) suffers permanent damage to their health within two years at the latest.

Under these terms and conditions, lifting, sprains, occupational diseases (harm), frostbite, sunstroke, heatstroke, disc injury, hernia, stroke, and non-accidental bleeding are not considered accidents. Suicide or attempted suicide shall not be considered an accident, even if committed by the insured person while in a state of mental confusion. Achilles tendon strain and/or rupture, ankle sprain and/or contusion and/or sprain are also not considered accidents, unless they occur during a traffic accident.

14. Events, body parts, organs and non-recoverable damages excluded from risk coverage (Exclusions)

14.1. Organs and body parts that were already permanently damaged or impaired prior to the accident are excluded from the insurer's risk coverage.

14.2. **The insurance does not cover:**
a) body parts or organs that were already damaged, injured, amputated or functionally impaired for any reason prior to the accident
b) accidents involving
– due to the insured driving a motor vehicle without a driving licence (excluding cases where the insured has a valid driving licence for the given category of motor vehicle but did not have it with them at the time of the accident)
– driving a motor vehicle with an expired driving licence or a driving licence that is not valid for the given category of vehicle,
– the insured person taking medication without medical advice or in doses other than those prescribed,
– the insured person was under the influence of alcohol, narcotics or other intoxicating substances,
c) due to the insured person's mental or conscious disorder, loss of consciousness for any reason, or suicide or attempted suicide,
d) as a result of physical injury caused by medical treatment and intervention performed on the insured person's body by themselves or with their consent by persons who are not medically qualified (unless this was due to an insured event),
e) accidents suffered during sporting activities (matches,

competitions, training) practisedas a professional1 or amateur athlete[2], as well as accidents occurring during organised mass sporting activities33(sports accidents),
f) any injury to teeth and dental prostheses,
g) bone fractures.

14.3. **The insurer shall not provide benefits under this supplementary insurance if the insured event**
a) the insured person's **active participation** in a terrorist act,
b) directly or indirectly as a consequence of or in connection with any terrorist act, except in the cases specified in this section, up to the limits specified therein.
Based on the terrorism referred to in points a) and b), the insurer's risk coverage does not extend to any damage caused directly or indirectly by any terrorist act or arising from or in connection with a terrorist act, regardless of the contributing cause or event occurring simultaneously or consecutively.

The insurer shall not provide services for any damage caused directly or indirectly by, or arising from, or related to, any activity carried out for the purpose of controlling, preventing, suppressing or reducing the events listed in points (a) and (b), or in any way related to them.

For the purposes of these contractual terms and conditions, a terrorist act is any act of violence or threat of violence that endangers human life, material and immaterial property, or infrastructure, which is committed for political, religious, ideological or ethnic objectives, or is aimed at influencing a government or causing fear in society or part of society, or is capable of doing so.

The insurer shall not assume any **risk for any** damage **caused** directly or indirectly **by** activities **carried out for the purpose of curbing, preventing, suppressing or reducing terrorist acts**, or **by** activities related to terrorist acts, **or arising from or in connection with such activities**.

15. Exemption of the insurer

15.1. **The insurer shall be exempt from its obligation to provide benefits if**
– the insured event is related to an accident involving the insured person that was caused unlawfully by the insured person or a relative living in the same household as the insured person, either intentionally or through gross negligence,
– the insured person's death was unlawfully caused by the intentional conduct of the beneficiary entitled to the insurance sum (the insured person or their heir).

15.2. **The insurer shall not make any payment or provide any service under this contract if such payment or service would violate any resolution of the United Nations or any law or regulation of the European Union, the United Kingdom or the United States.**

16. Services of the insurer

16.1. The insurer shall provide the services under this supplementary insurance in accordance with Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 11.B. b).

16.2. **In the event of permanent health impairment resulting from an accident, the total amount paid by the insurer may not exceed the benefit amount specified for permanent total health impairment.**

16.3. **In the event of multiple temporary health impairments resulting from an accident, the insurer shall pay the higher benefit amount.**

16.4. The insurer shall provide the insurance benefit within 15 days of the submission of the necessary documents (as detailed in Section 12.5 of these terms and conditions) in the event of permanent health impairment caused by an accident, based on the assessment of the extent of the health impairment within 15 days of the determination of the degree of permanent health impairment caused by an accident. The degree of permanent health impairment caused by an accident shall be determined within 15 days of the presentation of the necessary documents in the case of loss of the organs or limbs listed in Table 2. In the case of permanent health impairment not listed in Table 2.

In such cases, the extent of permanent health impairment shall be determined by the insurer's physician, including the loss of function of individual organs or limbs that does not result in their loss. The insurer's service shall be performed is considered to be a bank transfer. The date of payment is the date on which the amount payable is transferred from the insurer's account.

16.5. If the extent of permanent health impairment caused by the accident cannot be determined within 6 months of the claim being reported, the insurer shall, at the request

[1] **Professional athlete:** A professional athlete is a person who engages in sports activities for the purpose of earning income on the basis of an employment relationship or other legal relationship established with a sports organisation, or on the basis of a contract of mandate, and who holds a professional athlete's licence.
[2] **Amateur athlete:** An amateur athlete is anyone who holds a competition licence issued by any Hungarian or foreign sports club, sports association, sports society or other sports organisation for the purpose of participating in competitions or the competition system, which also includes a competition licence.
[3] **Organised mass sports activity:** Any event in which participants engage in sports activities and participation is subject to prior registration or any other form of prior enrolment shall be considered an organised mass sports activity.

of the insured, pay 50% of the benefit amount estimated by its own doctor as corresponding to the expected extent of health impairment as an advance payment. The insurer shall deduct the advance payment and the benefit amount paid for the temporary injury from the final amount of the benefit. When determining the extent of the health impairment, it is not the reduction in working capacity related to employment that shall be assessed, but the general functional impairment that can be taken into account in the performance of any work4.

16.6. If the insured person does not agree with the degree of permanent health impairment caused by the accident as determined by the insurer's doctor, they may request a review by the insurer.

16.7. The amount paid under this supplementary insurance is independent of the findings and services of social security institutions.

16.8. The insured person(s) are entitled to insurance benefits in the event of permanent health impairment resulting from an accident, accident-related inpatient hospital treatment, and bone fractures.

16.9. In the event of accidental death, the beneficiary named in the contract, or in the absence thereof, the insured person's heir(s) shall be entitled to the benefit.

2. Table

Damage of body parts, sensory organs	Service in the percentage of the insured sum
loss of vision of both eyes, loss of both upper arms/forearms or hands, loss of one arm or hand or leg (mutilation of an upper limb and a lower limb)	100
loss of both legs	90
loss of one thigh, loss of one arm	80
loss of one leg, loss of one arm, complete loss of speaking ability, complete loss of hearing in both ears	70
loss of one hand (below the wrist)	65
loss of one foot (below the ankle)	40
complete loss of the vision of one eye	35
complete loss of hearing in one ear	25

In the case of partial amputation of an organ, the amount of compensation shall be the corresponding percentage of the compensation percentage listed in the table.

17. Limitation period

The provisions relating to limitation are contained in Section 14.B. of the General Insurance Terms and Conditions of Allianz MyHome Insurance.

18. Due date

In the case of this supplementary cover, the due date for claims is:

a) in the event of death resulting from an accident, the date of the accident,
b) in the event of permanent health impairment or bone fracture resulting from an accident, the date of the accident,
c) in the case of accident-related inpatient hospital treatment, the date of the insured event.

[4] Work: In relation with this terms and conditions, the occupation or job position in which the insured worked directly preceding his/her incapacity for work. An insured will be disabled if he/she, as a result of an accident, cannot perform his/her work and cannot perform any other gainful activity due to his/her treatment necessary, in medical terms, in its own right.

Supplementary family life insurance

Special terms and conditions

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1. Contracting party, insured person, beneficiary

Policyholder
For the purposes of this supplementary insurance, the policyholder is the same as the policyholder of the basic insurance, Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, point 1.

Insured
The insured under the contract concluded on the basis of these terms and conditions shall be the natural person named as the insured in the policy, as well as their spouse living with them at the place of risk coverage of the Property Insurance, or a close relative living with them in the same household, provided that the person(s) listed above did not reach the age of 85 at the start of the risk coverage.

Under these terms and conditions:
- living at the place of risk: persons whose permanent address or valid temporary address is at the place of risk covered by the property insurance.
- Close relatives: spouse, direct relatives, adopted children, stepchildren and foster children, adoptive parents, step-parents and foster parents, as well as siblings.

Beneficiary
The beneficiary is the person who is entitled to the insurance benefit in the event of an insured event.

Unless otherwise specified, or if the beneficiary designation was not valid at the time of the insured event, the beneficiary of the death benefit is the insured's heir.

The policyholder may designate the beneficiary by means of a written statement addressed to the insurer and delivered to the insurer. If more than one beneficiary is designated, the proportion of the benefit must be specified. In the absence of such specification, the proportion of the benefit shall be deemed to be equal.

The policyholder may designate another beneficiary in place of any beneficiary by means of a written statement addressed to the insurer and delivered to the insurer prior to the occurrence of the insured event. The policyholder may revoke the designation at any time in the same form or designate another beneficiary in place of the designated beneficiary.

The written consent of the insured person is required for the designation or change of the beneficiary, unless the insured person is the policyholder. Any provision in a contract concluded without the consent of the insured person designating a beneficiary shall be null and void.

In such cases, the insured person or their heir shall be considered the beneficiary, who shall reimburse the policyholder for the premiums paid and the costs incurred in connection with the contract.

The policyholder may undertake, by means of a written statement addressed to the insurer and/or the beneficiary, to keep the designation of the beneficiary in force. The policyholder shall inform the insurer of the statement. Such beneficiary designation may not be changed or revoked without the consent of the insured and/or beneficiary.

The designation of the beneficiary shall cease to be effective if the beneficiary dies before the occurrence of the insured event or if the legal entity beneficiary ceases to exist without a legal successor. If the policyholder does not make a new declaration of beneficiary in such a case, but has previously designated several beneficiaries, the ratio of the remaining designations to each other shall determine the ratio of the beneficiaries.

2. Territorial and temporal scope

Supplementary insurance covers insured events occurring anywhere in the world during the risk coverage period of the basic insurance, following the risk coverage of the supplementary insurance. If the policyholder takes out supplementary insurance at a later date, the insurer shall bear the risk from the date of validity of the contract amendment as stated in the policy.

3. Conclusion of supplementary insurance

3.1. This supplementary insurance is linked to the Basic Insurance and, in this respect, may only be concluded under the Basic Insurance contract, either at the same time as the Basic Insurance is taken out or after the Basic Insurance has been taken out.

3.2. If the supplementary insurance is concluded after the conclusion of the Basic Insurance, the date of conclusion of the supplementary insurance shall be the day following the receipt of the declaration of conclusion by the insurer.

3.3. The policyholder may request an adjustment to the sum insured under this supplementary insurance, which will take effect as of the next policy anniversary.

4. Inception date of supplementary insurance

4.1. With regard to this supplementary insurance, the commencement of risk coverage:
- coincides with the commencement of risk coverage under the Basic Insurance, if it was concluded at the same time as the Basic Insurance contract,

– the date specified in the declaration concerning the conclusion of the supplementary insurance, or, in the absence thereof, 00:00 hours on the day following the receipt of the declaration by the insurer, if this supplementary insurance is concluded subsequently to an existing Basic Insurance contract.

4.2. With regard to this supplementary insurance, in the case of a new insured person, the insurer's risk coverage shall commence on the day on which the new insured person qualifies as an insured person in accordance with Chapter II, Section 1 of the special insurance conditions of the supplementary insurance, i.e. when they officially register at the place of risk coverage of the Property Insurance for the purpose of cohabitation.

4.3. In the case of several consecutive supplementary insurance policies, the insurance period shall be considered continuous if no more than 60 days have elapsed between the supplementary insurance policies linked to the Allianz MyHome insurance and covered by premiums, and the insured person is considered to be continuously insured.

4.4. In the case of this supplementary insurance, the insurer stipulates a waiting period of six months from the inception date.

For a new insured person, the waiting period begins on the date the applicable contract is entered into (which constitutes an extension of the current insurance coverage to include that person).

If the insured event
– occurs within the waiting period following the contract signing the insurer shall not provide insurance benefits, unless the insured person was continuously insured under a previous policy, in which case the insurer will provide insurance service based on the coverage provided under the previous policy.

5. Duration of supplementary insurance

The supplementary insurance is of indefinite duration.

6. Modification of supplementary insurance

The provisions governing the modification of supplementary insurance are contained in Section 5 of the General Insurance Terms and Conditions of Allianz MyHome Insurance.

7. Termination of supplementary insurance

7.1. This supplementary insurance shall terminate at the same time as the basic insurance contract.

7.2. The policyholder may terminate this supplementary insurance at any time in writing, while the basic insurance remains in force. The date of termination shall be the date specified by the policyholder in the notice of termination of the supplementary insurance, or, in the absence thereof, the date of receipt of the notice by the insurer.

7.3. This supplementary cover shall terminate on the insured person's 85th birthday.

7.4. This supplementary insurance has no residual value, i.e. the supplementary insurance contract has no surrender value and there is no possibility of premium exemption.

7.5. The policyholder may terminate the supplementary family life insurance by written notice within 30 days of the conclusion of the contract or the supplementary insurance. Allianz MyHome Insurance Benefits Guide, I. As set out in Section 6.B of the General Insurance Terms and Conditions. A natural person who concludes a life insurance contract outside the scope of their independent occupation or business activity may terminate the supplementary family life insurance contract by written notice within 30 days of receiving information about the conclusion of the contract and the supplementary insurance and the policyholder's right of termination without giving any reason. Upon receipt of the policyholder's notice of termination, the insurer shall, within 15 days, settle any payments made by the policyholder in connection with the insurance contract or supplementary insurance on any legal basis. The policyholder may not validly waive his or her right of termination.

7.6. Further provisions regarding the termination of supplementary insurance due to loss of interest or impossibility are contained in Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 6.

8. Premium of the supplementary insurance

The insurance premium shall be paid in Hungarian forints together with the premium for the Basic Insurance and at the same frequency of payment as the Basic Insurance. If the supplementary insurance is taken out after the conclusion of the Basic Insurance, the first premium for the supplementary insurance shall be determined in accordance with Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 7.3.2.

9. Sum Insured of the supplementary insurance

9.1. The initial sum insured for the supplementary insurance is determined by the policyholder.

9.2. The initial minimum sum insured for supplementary insurance is HUF 200,000, which can be multiplied up to HUF 2,000,000 in increments of HUF 200,000.

10. Rules of indexation

The sum insured and premium for supplementary insurance shall change in proportion to the indexation of the sums insured and premiums for basic insurance. In other respects, the rules on indexation are set out in the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 9.

11. Deductibles

The insurer shall not deduct any excess if it provides benefits under the supplementary family life insurance.

12. Obligations of the insured person and beneficiary

12.1. Obligation to notify and report changes
The rules relating to notification and change reporting obligations are set out in Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 11. A. b), with the additions set out in Sections 12.2 to 12.5 below.

12.2. The insured person's contribution to the establishment of insurance cover also means that they undertake to allow the insurer to verify the information provided (including proof of the insured person's age required for the payment of insurance benefits).

12.3. Any change in the insured person's data is considered a material circumstance in terms of risk assumption. The insurer may request information from the policyholder and the insured person on matters that are relevant to the assumption of risk. Such a relevant matter is the verification of data for the purpose of compliance with the Foreign Account Tax Compliance Act (FATCA).

12.4. If the information provided in response to the insurer's questions proves to be untrue (breach of the duty of disclosure), the insurer shall not be liable to pay
a) with regard to insurance coverage,
b) with regard to the difference between the insurance sums before and after an increase in the insurance sum.

12.5. The insurer's obligation shall arise
a) with regard to the insurance coverage,
b) in relation to the difference between the amounts before and after the increase in the sum insured when the sum insured is increased,
if it is proven that the insurer concealed or failed to report the circumstances at the time the insurance cover was established, or when the sum insured was increased, or during the term of the insurance cover at the time of renewal, or did not contribute to the occurrence of the insured event.

12.6. **Obligation to report damage (report an insured** event) The insured event must be reported to the insurer within 8 working days of its occurrence. Further rules relating to the reporting of claims are set out in Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, point 11.A. d).

12.7. **Documents required for reporting a claim (for the provision of services)**
The following documents must be submitted to the insurer to verify the occurrence of the insured event and to determine the extent of the service to be provided:

A. Documents certifying the occurrence of the death
- a copy of the death certificate,
- a copy of the medical or official certificate confirming the cause of death (post-mortem certificate).

B. Identity documents
a) Documents, certificates and data certifying the identity of the natural person entitled to claim the benefit or the legal entity, such as
   - for natural persons: identity card or passport or card-format driving licence, as well as an official document certifying their address, plus a tax identification document – e.g. tax card or, in the case of a natural person who is not a Hungarian tax resident and does not have a Hungarian tax identification number, a copy of a document containing the tax identification number of the country of tax residence
   - in the case of a legal entity: a company register number or registration number and tax number, and a company extract not older than 30 days, and tax identification document, and in the case of a legal entity without Hungarian tax residency and without a Hungarian tax number, a copy of a certificate of residency issued by the tax authority of the country of tax residency, not older than 30 days,

b) documents certifying the procedural authority of the natural person acting on behalf of the legal entity entitled to use the service.

C. Official documents
- any official proceedings initiated in connection with the reported insured event, reports of on-site inspections conducted during investigations, expert

opinions, hearing reports, official notifications and certificates,
- the final decision concluding the administrative proceedings initiated in connection with the reported insured event,
- official documents related to the traffic accident (the driver's valid driving licence orin the absence of a driving licence, an official certificate issued by the competent ministry authorised to issue driving licences, registration certificate),
- if the insured person's heir is entitled to the service, a final notarial or court decision on inheritance, or a copy of the certificate of inheritance,
- if the person entitled to the payment is a minor, proof of the legal representative's authority to act on their behalf,
- if the person entitled to receive the payment is under guardianship, a decision by the guardianship authority confirming the identity of the guardian acting on their behalf,
- if required by separate legislation, a guardianship office authorisation for the payment,
- documents certifying the insured status (e.g. title deed) confirming that the insured person is the person registered at the place of risk coverage under the property insurance.

D. Medical documents
- copies of the family doctor's medical records and treatment records, copies of specialist and hospital treatment documents,
- certificates issued by the National Health Insurance Fund (NEAK) and its legal predecessors, as well as data processed by it, health documents available on the Electronic Health Service Space (EESZT) interface
- copies of autopsy reports,
- official certification of the results of alcohol consumption tests,
- official medical documents or official decisions concerning the examination of the effects of narcotic or other intoxicating substances,
- documents relating to medical diagnostic procedures (e.g.

X-rays, MRI, CT scans),
- medical or official confirmation of burn injuries (fire brigade decision),
- copies of all documents related to medical treatment,
- post-mortem medical report,

E. Documents related to the insurance contract
- detailed report describing the insured event,
- power of attorney in the case of authorised representation,
- in the case of taxable insurance services, documents necessary for determining the amount of tax to be deducted by the insurer.

F. Additional documents required for payment
- identification data sheet,
- declaration of beneficial ownership,
- declaration of prominent public figures, close relatives of prominent public figures, or persons in a close relationship with them,
- declaration of tax residency,
- the payment transfer order,
- in the case of persons residing abroad, a statement of residence abroad, and
- in the case of non-Hungarian tax residency, the foreign tax identification number and a copy of the certificate containing it (a bilingual certificate issued by the tax or other authority of the country of tax jurisdiction – CERTIFICATE OF RESIDENCY – containing the tax identification number of the country concerned),
- a statement in the event of sanctions.

G) Additional documents required for payment to heirs
The documents specified in the section entitled „Processing of personal data" of the document entitled „Data Processing and Customer Information in connection with the General Terms and Conditions and Customer Information, as well as the Supplement to the Terms and Conditions" in connection with the processing of the heirs' data.

In the event of an insured event occurring abroad, the insurer may request the presentation of a certified translation of the documents into Hungarian, prepared at the expense of the beneficiary.

The insurer is not obliged to return the documents submitted for the assessment of entitlement to benefits unless the insured expressly requests this.

In addition to the items listed in points A-G) above, the insured person is also entitled to prove the insured event in other ways in accordance with the general rules of evidence.

12.8. The insurer is entitled to check the content of the medical documents submitted in connection with the occurrence of the insured event and to review the insured person's state of health, the necessity of the medical procedure and the duration of treatment. The insured person acknowledges that the review of their state of health may include an examination by the insurer's doctor.

12.9. In individual cases, the insurer may also request the opinion of an independent medical expert. The insured person agrees to undergo an examination by the insurer's doctor.

12.10. Unless otherwise specified in the special insurance terms and conditions, the insurer shall pay the benefit to

the beneficiary within 15 days of receiving the documents listed in Section 12.7. The insurance benefit shall be deemed to have been paid by means of a bank transfer. The date of payment shall be the date on which the amount payable is transferred from the insurer's account.

12.11. The insurer shall be obliged to handle and store the findings of the medical examinations it has carried out, as well as the documents related to the insurance and those received or prepared during the settlement of claims, in accordance with the rules on data processing.

13. Insured events

13.1. Under the terms and conditions of this contract, an insured event is the death of the insured person during the risk period for any reason, with the proviso that death occurring within two years of the commencement of the risk period is an insured event if
a) the insured person did not have any diagnosed illness at the time of concluding the contract that was the direct cause of death, or if
b) the death resulted from an illness already diagnosed at the time of concluding the contract and the insured person was continuously insured for the 6 months the date of conclusion of the contract.

14. Events, body parts, organs and non-recoverable damages excluded from risk coverage (Exclusions)

14.1. The insurer shall not provide coverage under this supplementary insurance policy if the insured event
a) the insured person's active participation in a terrorist act
b) directly or indirectly as a consequence of or in connection with any terrorist act, except in the cases specified in this section, up to the limits specified therein.

Based on the terrorism referred to in points a) and b), the insurer's risk coverage does not extend to any damage caused directly or indirectly by any terrorist act or arising from or in connection with a terrorist act, regardless of the contributing cause or event occurring simultaneously or consecutively.

The insurer shall not provide services for any damage caused directly or indirectly by, or arising from, or related to, any activity carried out for the purpose of controlling, preventing, suppressing or reducing the events listed in points (a) and (b), or in any way related to them.

For the purposes of these contractual terms and conditions, a terrorist act is any act of violence or threat of violence that endangers human life, material and immaterial property, or infrastructure, which is committed for political, religious, ideological or ethnic objectives, or is aimed at influencing a government or causing fear in society or part of society, or is capable of doing so.

The insurer shall not assume any risk for any damage caused directly or indirectly by activities carried out directly or indirectly for the purpose of preventing, suppressing or reducing terrorist acts, or caused directly or indirectly by activities related to terrorist acts, or arising from or in connection with such acts.

The insurer shall not make any payment or provide any service under this contract if such payment or service would violate any resolution of the United Nations or any law or regulation of the European Union, the United Kingdom or the United States.

15. Exemption of the insurer

15.1. The insurer shall be exempt from any obligation to pay death benefits for any cause if the death of the insured
a) was caused by the intentional conduct of the insured person or the beneficiary (the insured person's heir)
b) was the result of a serious criminal offence committed unlawfully and intentionally by the insured person or in connection with such an offence, or
c) due to suicide committed within 2 years of the commencement of risk coverage.

15.2. The insurer shall not make any payment or provide any service under this contract if such payment or service would violate any resolution of the United Nations or any law or regulation of the European Union, the United Kingdom or the United States.

16. Services of the insurer

16.1. The insurer shall provide the service under this supplementary insurance in accordance with Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 11.B. b).

16.2. In return for the payment of the insurance premium specified in the contract, the insurer undertakes to provide the following lump sum benefit to the beneficiary in the event of an insured event occurring during the term of the insurance (the period of risk coverage):
– in the event of death for any reason, the current sum insured (increased by the consumer price index applicable during the term of the insurance, the insured eventat the time of occurrence) or part thereof as follows. The amount of the insurer's benefit depends on the age of the insured persons.

Age of the insured (at the occurrence of the insurance event)	Services provided by the insurer
younger than 30	200% of the actual sum insured
30 years old or older, but younger than 40 years old	150% of the actual sum insured
40 years old or older, but younger than 55 years old	100% of the actual sum insured
55 years old or older, but younger than 65 years old	50% of the actual sum insured
65 years old or older, but younger than 85 years old	20% of the actual sum insured

17. Limitation period

The provisions relating to limitation periods, Allianz MyHome Insurance Information, I. General Insurance Terms and Conditions, Section 14.B.

18. Due date

In the case of this supplementary insurance, the due date for the claim for benefits is the date of death of the insured person.

19. Information on FATCA and other international tax compliance legislation

19.1. FATCA (Foreign Account Tax Compliance Act), i.e. the US law on tax compliance for foreign accounts.

19.2. Other international tax compliance legislation:
The international agreement on automatic exchange of information introduced by the Organisation for Economic Co-operation and Development (OECD) and the European Union.

19.3. In order to ensure compliance with the provisions of Act XXXVII of 2013 on certain rules of international administrative cooperation in relation to taxes and other public levies (Aktv.) (which includes provisions relating to both FATCA and other international tax compliance regulations), the insurer shall inform the policyholder of the following measures.

19.4. With regard to this supplementary insurance, when providing the service, the insurer is obliged to verify the beneficiary's residence and Hungarian tax and shall be obliged to provide data to the tax authority in the cases specified in the Act, as well as to fulfil its reporting obligation comply .

19.5. Residency verification means that the beneficiary must make a declaration stating their country of tax residency and, in the case of legal entities, the country in which they were established. If they are tax residents of another country, they are required to provide their numerical identification number issued to them by the competent tax authority.

19.6. Based on the residence check performed, the insurer shall report data information to the Hungarian tax authority, in the cases and within the time limits specified in the Aktv.

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Information on supplementary health insurance for high-value diagnostic care

These Terms and Conditions contain the provisions applicable to the Supplementary health insurance for high-value diagnostic care (hereinafter: Supplementary Insurance) concluded between Allianz Hungária Zrt. (hereinafter: Insurer) and the Policyholder for the Allianz MyHome Insurance (hereinafter: Basic Insurance) concluded between Allianz Hungária Zrt. (hereinafter: Insurer) and the Policyholder, provided that the supplementary insurance was concluded with reference to these Contractual Terms and Conditions.

If this condition differs from the General Insurance Terms and Conditions of Allianz MyHome Insurance or the Special Insurance Terms and Conditions of Property Insurance Coverage, the provisions of these terms and conditions shall prevail.

In matters not regulated by these Supplementary Health Insurance Terms and Conditions for High-Value Diagnostic Care or the General and Special Insurance Terms and Conditions of Allianz MyHome Insurance, the provisions of Act V of 2013 on the Civil Code (hereinafter referred to as the Civil Code) Act LXXXVIII of 2014 on Insurance Activities and the provisions of the Hungarian legislation in force shall apply.

Special insurance conditions

1. Contracting party, insured party, beneficiary

Contracting party

The policyholder of this supplementary insurance is the same as the policyholder of the basic insurance.

Insured

The insured person is the natural person named in the insurance contract (offer, policy) as the insured person, provided that this person is the same as the policyholder and their address is the same as the risk location specified in the contract.

place of residence, as well as natural persons living at the place of risk who have the place of risk specified in the Basic Insurance as their place of residence or place of stay on their address card, provided that the conditions specified in these terms and conditions relating to the insured person (e.g. age of entry) are met. Persons whose address on their residence card matches the place of risk coverage specified in the Basic Insurance are entitled to use the service.

The insured person is entitled to the services of this supplementary insurance.
The insured person's age of entry may be between **2 and 69 years** at the time of taking out the supplementary insurance.

Date of commencement of insurance cover	Method of determining the entry age
At the same time as the Basic Insurance takes effect	At the time of commencement of risk coverage under the Basic Insurance, the actual age of the insured person, number of years of age reached E.g. Start of risk coverage for the Basic Insurance: 11 October 2024, date of birth of the insured person: 10 December 2002. Age of entry of the insured person = 21 years.
During the term of the Basic Insurance	the insured person's actual age at the start of the risk coverage for the supplementary insurance, number of years of age reached E.g. Start of risk coverage for supplementary insurance: 1 November 2025 Date of birth of the insured person: 10 December 2002. Age of entry of the insured person = 22 years.

If the insured person is a minor and the contract is not concluded by his or her parent exercising legal representation, or if the insurance cover is not initiated by his or her parent exercising legal representation, the approval of the guardianship authority is required for the contract and the cover to be valid. The approval of the guardianship authority is required for the conclusion of the contract and the establishment of insurance coverage if the insured person is an adult with limited legal capacity or is legally incompetent with regard to financial matters.

2. Information about insured events and services

Health insurance service: Based on the insurer's risk coverage for the health insurance policy taken out by the insured, during the risk coverage period, in the event of an insured event specified in the insurance terms and conditions, the insurer shall provide a service in the form of a non-insurance sum, which covers medical expenses, as well as the costs of health services and other services, as specified in these Terms and Conditions.

Healthcare service: Healthcare activities that may be performed with an operating licence issued by the state healthcare administration.

Healthcare provider: Any individual healthcare entrepreneur or legal entity authorised to provide healthcare services on the basis of an operating licence issued by the state healthcare administration, regardless of its form of ownership or maintainer.

Care organiser: The healthcare provider that provides the insured person with the services specified in these Terms and Conditions of Contract on the basis of a contract concluded with the insurer.
in accordance with these Terms and Conditions. **Name, address and telephone number of the healthcare provider contracted by the insurer:**
Teladoc Hungary Kft.
1083 Budapest, Szigony utca 26-32. III. em.
Phone: +36 (1)510-0522

Period available for reporting requests for care coordination services by telephone: on working days between 8:00 a.m. and 8:00 p.m.

Examination: An activity aimed at assessing the patient's state of health, detecting diseases and risks, determining specific diseases, establishing their prognosis and changes, and determining the effectiveness of treatment.

Specialist: A doctor with a valid specialist qualification and operating licence, not including doctors with qualifications in general practice, occupational medicine or disaster medicine.

Pre-existing condition: Any symptom, injury, illness, lesion or permanent impairment that occurred prior to the commencement of the risk period and has already been diagnosed, or any symptom, injury, illness, lesion or permanent impairment that has not yet been diagnosed, as well as any illness, condition or change which, due to its nature, developed prior to the commencement of the risk coverage period in accordance with general medical guidelines and in causal connection with which the insured person requested or used healthcare services during the risk coverage period.

In the event of a pre-existing condition or accident that can be proven to have existed prior to the commencement of the risk coverage, the insurer shall be entitled to reject the claim for benefits.

Service limit: Based on the supplementary insurance – according to the data on the insured persons' address cards – the maximum amount of services that can be used in total by insured persons registered at the same address during the insurance period specified in the Basic Insurance, as set out in this supplementary insurance. The limit is specified in Hungarian forints. The limit is determined by the insurer. A combined limit applies to insured persons registered at the same address; no individual limit is specified for each insured person. The service limit applicable to the supplementary insurance is specified in the insurance policy.
Any costs incurred for services used in excess of the limit shall be paid by the insured person.

3. Territorial and temporal scope

Supplementary insurance **covers insured events occurring in Hungary** during the risk coverage period of the basic insurance, **as well as healthcare services used at a healthcare provider based in Hungary** or at a specialist practising in Hungary, after the start of the supplementary insurance risk coverage. If the policyholder takes out supplementary insurance at a later date, the insurer shall bear the risk from the date of validity of the contract amendment as stated in the policy.

Non-monetary health insurance services organised by the care provider **may only be used within Hungary**, provided that the contract has been settled with a premium. **The insurer does not provide services for health insurance services not organised by the care provider.**

4. Conclusion of supplementary insurance

This supplementary insurance is linked to the Basic Insurance and, in this respect, may only be taken out under the Basic Insurance contract, either at the same time as the

Basic Insurance is taken out or after the Basic Insurance has been taken out.

If the supplementary insurance is taken out after the basic insurance has been concluded, the date of commencement of the supplementary insurance shall be the day following the date of receipt by the insurer of the declaration of conclusion, provided that the insurer has accepted it by issuing a statement of acceptance (policy) within the risk assessment period available to it.

In all other respects, the provisions of the Basic Insurance shall govern the conclusion of the supplementary insurance.

5. Inception date of supplementary insurance

With regard to this supplementary insurance, the commencement of risk coverage:
- coincides with the commencement of risk coverage under the Basic Insurance, if it was concluded at the same time as the Basic Insurance contract,
- the date specified in the declaration concerning the conclusion of the supplementary insurance, or, in the absence thereof, 00:00 hours on the day following the date of receipt of the declaration by the insurer, if this supplementary insurance is taken out retrospectively in relation to an existing Basic Insurance Contract, provided that the insurer has accepted it by issuing a statement of acceptance within the risk assessment period available to it.

6. Duration of the supplementary insurance

6.1. The supplementary insurance is concluded for a fixed term of one year.

6.2. **The one-year term** of the supplementary insurance **shall be automatically extended by** one year in accordance with **the provisions of this clause**, unless either party notifies the other party in writing of its intention not to do so at least 30 days before the anniversary of the insurance contract (i.e. the expiry of the term of the supplementary insurance). This does not affect the contracting party's right of ordinary termination.

6.3. **The term of the supplementary insurance shall be automatically extended until all insured persons covered by the contract reach the age of 70, after which the supplementary insurance shall terminate.**

6.4. The term of the supplementary insurance cannot be extended after reaching the above age, following the termination of the supplementary insurance.

7. Modification of supplementary insurance

The provisions governing amendments to supplementary insurance are contained in the Allianz MyHome Insurance Benefits Guide, section I. General Insurance Terms and Conditions, point 5.

8. The premium for supplementary insurance

8.1. The insurance premium shall be paid in Hungarian forints together with the premium for the Basic Insurance and at the same frequency as the Basic Insurance.

8.2. If the supplementary insurance is taken out after the Basic Insurance has been concluded, the first premium for the supplementary insurance shall be determined in accordance with the provisions of Section 7.3.2 of the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions.

9. Rules for modifying insurance premiums and service limits

9.1. We shall notify the policyholder of any increase in the benefit limit and insurance premium by the insurer 60 days before the anniversary date specified in the Basic Insurance. The benefit limit and insurance premium may increase at different rates.

9.2. If the policyholder does not wish to maintain the supplementary insurance at the premium offered by the insurer, they must notify the insurer 30 days before the anniversary date. In this case, the supplementary insurance will terminate on the anniversary date.

9.3. Otherwise, the rules governing limitation are set out in the Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 9.

10. Deductibles

The insurer shall not deduct any excess if it provides services on the basis of the supplementary insurance or the insurance cover included therein.

11. Obligations of the policyholder and the insured

Obligation to notify and report changes

11.1. During the term of the business relationship, the policyholder and the insured person shall notify the

insurer of any changes in the data provided at the time of concluding the contract within 8 working days of becoming aware of such changes.

The insurer must be notified of any changes to the following data, as well as any changes to the data contained in the offer. In the case of a natural person policyholder and/or insured person:
– first and last name, and
– address.

Further rules on the obligation to provide information and report changes are contained in Allianz MyHome Insurance Information I. General Insurance Terms and Conditions, Section 11. A. b).

11.2. The policyholder must notify the insurer if all insured persons at the place of risk have reached the age of 70. The notification must be made within 8 working days of reaching the age or becoming aware of it.

In addition to the above, the policyholder and the insured person are obliged to
– their postal address,
– their e-mail address,
– their telephone number capable of receiving text messages to the insurer within 8 working days of any changes occurring during the term of the contract. The insurer may lawfully send statements or notifications to the last known contact details listed

above until the relevant change notification has been received by the insurer.

11.3. The possibility of natural deterioration in health due to the insured person's advancing age shall not be considered a significant increase in insurance risk.

12. Insured event

An insured event is a medically justified examination for diagnostic purposes (CT, MRI, PET-CT, Cardio-CT) is necessary and medically justified, provided that the accident or illness leading to the insured event also occurred during the risk period of this supplementary insurance.

Under these Terms and Conditions, **high-value diagnostic care is defined** as a diagnostic examination specified in this supplementary insurance, performed in accordance with medical regulations by a person with medical qualifications or, on their recommendation, by another person with the appropriate healthcare qualifications.

The insurer applies the exclusions specified in the insurance policy.

13. Services of the insurer

13.1. The insurer undertakes to provide the insured with the following services at a pre-arranged appointment, organised or pre-approved by the care provider contracted by the insurer, in the event of an insured event.

High-value diagnostic tests:
a) CT
b) MRI
c) PET-CT
d) Cardio-CT

The cost of laboratory tests of kidney function required for contrast-enhanced examinations, as well as CT angiography and MR angiography examinations. Supplementary insurance services **are** healthcare services **organised or pre-approved by the healthcare provider**.

13.2. The insurer shall provide the high-value diagnostic care service during the term of the supplementary insurance, **in a single insurance year, for insured persons registered at the place of risk coverage, up to the maximum amount specified in the insurance policy for the given insurance period**.

The service may be used by one or more insured persons registered at the place of risk based on the data on the insured person's address card, up to the above limit.

13.3. When utilising the limit amount, requests received by the care organiser shall be considered in chronological order according to the date of receipt of the service request and all documents required for the request by the care organiser. The care organiser shall examine the service requests received in chronological order and inform the insured person of the order in which the requests will be considered, whether there is already a claim in progress under the given contract, and whether the available limit is expected to be sufficient for the service or whether the requested care is not covered by the insurance due to the limit being run out.

In terms of the limit, the date of receipt of all documents required for the claim is decisive.

14. Events excluded from risk coverage, non-recoverable damages (exclusions)

In the following cases, the insurer shall not provide any services, given that no insured event has occurred.

14.1. **General rules**

The following are not considered insured events, and therefore the insurer will not provide insurance services if the insured person's accident or illness

a) **occurs in the course of war, civil war or combat, during occupation, during acts of external enemies, during hostilities or – without a declaration of war without a declaration of war**, in connection with **military operations, uprisings, rebellions, riots, disturbances or civil unrest, popular uprisings, popular movements, military uprisings or revolutions**.
b) **military or other takeover, military administration, state of emergency or any event leading to the declaration or maintenance of military administration or a state of emergency**,
c) due to the insured's **active participation in a terrorist act**,
d) directly or indirectly as a consequence of or in connection with any **terrorist act**,
e) due to **structural changes in the atomic nucleus or the effects of radioactive radiation or other ionising radiation sources** (if not used for therapeutic purposes),
f) **atomic, biological or chemical weapons, or radioactive, biological or chemical substances**, whether directly or indirectly attributable to the use of such weapons or substances, – company premises and other real estate (e.g. nuclear power plants, reprocessing plants, permanent or temporary waste disposal sites, research reactors, warehouses or factories), or parts thereof, land, movable assets (e.g. transport or storage containers) due to an attack or deliberate intrusion leading to the release of radioactivity or atomic, biological or chemical weapons or components thereof;

occurred, or occurred in direct or indirect connection with the above.

Based on points a) and b), **the insurer's risk coverage does not extend to any natural disaster caused directly or indirectly by any of the events listed above, or arising from or in connection with such events**, regardless of the contributing cause or event occurring simultaneously or consecutively.

The insurer shall not provide services for any damage caused directly or indirectly by, or arising from, or related to any activity carried out for the purpose of controlling, preventing, suppressing or reducing the events listed in points a) and b), or in any way related to them. Based on the terrorism listed in points c) and d), **the insurer's risk coverage does not extend to** any damage caused directly or indirectly **by** any **act of terrorism, or arising from or related to any act of terrorism**, regardless of the contributing cause or event occurring simultaneously or consecutively.

For the purposes of these Terms and Conditions, **an act of terrorism** is any violent or threatening act of violence against human life, material and immaterial property, infrastructure an act that is dangerous to public safety, which is motivated by political, religious, ideological or ethnic objectives, or which is aimed at influencing a government or causing fear in society or part of society, or which is capable of doing so.

The insurer shall not assume any **risk** for any damage **caused** directly or indirectly **by activities carried out for the purpose of preventing, suppressing or reducing terrorist acts, or in connection with terrorist acts, or arising from or related to such activities**.

The insurer shall also not provide services if the attack or intrusion referred to in point f) **was caused by the use of information technology tools**.

In this case, the insurer shall not provide services related to the insured's health insurance coverage.

14.2. **Special cases of exclusion**

14.2.1. **In the case of supplementary insurance, the insurer shall not provide benefits if the insured person's** complaints arising from **the insured event or** the accident or probable illness leading to it are due to

a) taking **medication without medical advice or in doses other** than **those prescribed**,
b) as a result of **physical damage caused by therapeutic treatment and intervention performed** on his/her body **by** himself/herself or, with his/her consent, **by** other **persons who are not medically qualified** (unless this occurs as a result of an insured event), or
c) **driving a motor vehicle without a valid driving licence or valid registration certificate**,
d) **in the event of sanctions, in accordance with the section of these contractual terms and conditions entitled „Method and time of service provision**", or
e) in connection with an accident suffered during **sporting activities** (matches, competitions, training) **practised as a professional or amateur athlete**, as well as accidents that occurred during **organised mass sporting activities** (sports accidents),
f) **in connection with sports activities**.

A **professional athlete** is someone who has an employment relationship or other legal relationship for the purpose of performing work with a sports organisation, or who engages in sports activities for the purpose of earning income on the basis of a contract of mandate, and who holds a professional athlete's licence.
An amateur athlete is anyone who, for the purpose of earning income, participates in sports activities organised by any Hungarian or foreign sports club, sports association,

sports society or other sports organisation for the purpose of earning income, and who is registered in the competition system or holds a competition licence that entitles them to participate in competitions.

Any event in which participants engage in sporting activities, which is not organised by the contracting party and which requires prior registration or any other form of advance registration, shall be considered an **organised** mass sporting event.

The following are considered **extreme** sports:
- any professional or amateur sporting activity that requires special conditions or special sports equipment to practise, and
- any sporting activity during which the insured person leaves the designated course for the sporting activity,
- all amateur and professional sports activities aimed at achieving competitive results (including recreational sports practised under competitive conditions), as well as training in preparation for competitions.

The definition of extreme sports in this insurance policy differs from the definition specified by the National Health Insurance Fund.

The following sports, in particular, but not exclusively, are considered extreme sports: obstacle course racing (including Spartan races), American football, off-road driving (including, in particular, off-road rallying), caving, cave diving, bungee jumping, diving to depths exceeding 5 metres, canyoning, downhill cycling, wall climbing, skateboarding in skate parks, martial arts, mountaineering, mountain biking, hot air ballooning, hydrospeed, jet skiing, cycling off public roads, combat sports, high mountain hiking, long-distance running (over 21 kilometres), use of sports equipment towed by motorboat (including, in particular, parachuting and water skiing), rafting (white water rafting), rugby, hang gliding, paragliding, rock climbing, rock jumping, surfing (including windsurfing and kitesurfing), sea kayaking, sea canoeing, flying in a glider or motor glider, motorcycling off public roads, aerobatics, quad biking, competitive dancing, via ferrata, sailing, parasailing, water skiing, wakeboarding.

The following activities are considered mountaineering:
- hiking in mountainous terrain, if the hiker deviates from the designated tourist trail (regardless of altitude),
- hiking in mountainous areas if road conditions require the use of special equipment (e.g. rope safety equipment, crampons, ice axes, etc.),
- hiking above 3000 metres,
- hiking on via ferrata routes with a difficulty rating higher than „C" according to the Austrian classification.

If any section of the climbing route meets any of the above conditions, hiking on other sections of the route is also considered climbing.

14.2.2. **With regard to supplementary insurance, the insurer's coverage does not extend to body parts or organs that were already damaged, injured, amputated or functionally impaired for any reason prior to the accident, if this can be proven to be related to the current claim on the basis of medical documentation.**

14.2.3. **The following are not considered insured events, therefore the insurer shall not provide insurance services for the following benefits and any related or requested diagnostic examinations in the following cases**
a) care related to an accident or illness that occurred prior to the start of the risk period,
b) interventions and treatment related to infertility,
c) emergency care or examination,
d) examination or treatment related to sexually transmitted diseases,
e) cosmetic examinations or procedures,
f) expert activities, expert opinions, medical fitness examinations, prescription writing, specialist recommendations, examinations or care for the purpose of obtaining a medical report,
g) examinations or care related to termination of pregnancy or artificial sterilisation not based on medical indications,
h) diagnostics necessary for dental and oral surgery problems,
i) virtual endoscopy, capsule endoscopy and other endoscopic examinations,
j) enterography examinations,
k) catheter angiography (coronary angiography).

14.2.4. **The insurer does not provide reimbursement for the costs of anaesthesia or sedation related to the use of diagnostic services and any additional care associated with it.**

15. Reporting an insured event

15.1. The insured person shall report the insured event to the care organiser by telephone and, at the request of the care organiser, by sending the documents necessary for the service or providing the necessary data.

In order to use the service, the insured person must report the claim to the care organiser and, after identifying themselves with the data specified below, provide the care organiser with the documents specified in these terms and conditions.

Data required for identification:
– the contract number of the basic insurance contract,
– the data appearing on the address card of the insured person reporting the claim,
– the name of the insured person reporting the claim,
– the name of the insured person's mother,
– the insured person's date of birth.

When reporting a claim for services by telephone, the care organiser shall always identify the insured person on the basis of their address and contract number. The care organiser shall verify entitlement to services on the basis of the address card, a copy of which the insured person is obliged to send to the care organiser.

When using the healthcare services organised by the care organiser, the healthcare provider will identify the insured person based on their personal data. If the insured person cannot be identified, the cost of the healthcare service used will be paid by the insured person at the time of care.

15.2. The healthcare provider is entitled to check the content of the medical documents submitted in connection with the insured event, to review the insured person's state of health and the necessity of the medical procedure. As a result of the review, the care organiser may refuse to organise the healthcare service in cases where it is not medically necessary and therefore not justified.

The insurer is entitled to check the content of the medical documents submitted in connection with the occurrence of the insured event and to review the insured person's state of health and the necessity of the medical procedure. In individual cases, the insurer may also request the opinion of an independent medical expert.

15.3. **Documents to be submitted to certify the insured event**

The documents necessary to certify the occurrence of the insured event and to determine the extent of the service to be provided must be submitted or presented to the insurer.

In order to prove and assess the claim for the insurer's services, the care organiser may request the presentation of the following documents:
– referral from a specialist for treatment,
– medical documentation certifying the need for medical care,
– if the person entitled to use the service is a minor, proof of the legal representative's authority to act on their behalf,
– an invoice issued in the name of the insured person,
– document certifying the insured person's place of residence or stay (official certificate confirming their address).

The care organiser shall commence the organisation of care after the above documents have been made available.

In order to verify the insured event and provide the insurance service, the insurer may request the submission or presentation of the following documents:

A) Identity documents
– documents, certificates and data certifying the identity of the natural person entitled to use the service, such as the natural person's identity card or passport, or card-format driving licence and official certificate confirming their address.

B) Official documents
– official documents related to the traffic accident (driving licence, vehicle registration certificate),
– if the person entitled to use the service is a minor, proof of the legal representative's authority to act on their behalf and, if the legal representative is not acting on behalf of the minor, the approval of the guardianship authority as specified in point 1.3,
– if the person entitled to use the service is under guardianship, a decision of the guardianship authority certifying the identity of the guardian acting on their behalf, as well as approval of the guardianship authority as specified in point 1.3.

C) Medical documents
– a copy of the family doctor's medical records and treatment records, a copy of the specialist and hospital treatment documents,
– Certificates issued by the National Health Insurance Fund and its legal predecessors, as well as data processed by it,
– documents certifying hospitalisation, copies of final reports and outpatient treatment records,
– copies of surgical reports containing detailed descriptions of the operation(s),
– official confirmation of the results of intoxication tests,
– official medical documents or official decisions on the effects of narcotics or other intoxicating substances,
– documents relating to medical diagnostic procedures (e.g.
X-rays, MRI, CT scans),
– copies of all documents related to medical treatment.

The insurer is not obliged to return the documents submitted for the assessment of entitlement to benefits unless the insured person expressly requests this.

In addition to the items listed in points A-C), the insured person may also be entitled to prove the insured event

in other ways in accordance with the general rules of evidence.

The insurer is entitled to retain the findings of medical examinations and documents related to the insurance in accordance with the rules on data processing.

16. General rules for the provision of supplementary insurance services

Method and timing of service provision

16.1. **In the event of an insured event, the insurer shall provide the insurance service covered by the insurance policy.** The insurer shall provide the service on the basis of the provisions of the person entitled to the service.
In the event of an insured event, the insured person shall not be subject to any obligation to maintain the status quo.

The insurer **shall not provide any service or make any payment** under this supplementary insurance if the provision of such service or payment would violate any resolution of the United Nations or any law or regulation of the European Union, the United Kingdom or the United States.

16.2. **The insurer shall provide the service as specified below and at the specified time:**
The care coordinator shall arrange the examination within 10 working days of the insured person submitting their request for the examination, provided that all the documents necessary for arranging the care are available, and shall notify the insured person of the date and location of the examination. The care organiser shall notify the insured person in the manner specified by the insured person (by e-mail or telephone).
The 10-working-day deadline does not apply to the date of the examination.

16.3. **The insurer may limit the supplementary insurance service by setting a limit.**

The supplementary insurance covers the period from the start of the risk coverage until the first anniversary thereafter; the limit applicable to the service available in a subsequent insurance year is specified in the insurance policy.

Prior to organising the care, the care organiser shall notify the insured person if, taking into account the requested care and the cost of the care, the value of the services would exceed the limit applicable to supplementary insurance.

The insured person may use healthcare services above the limit at their own expense. **The insurer and the care organiser acting during the provision of the service shall not organise care for healthcare services above the limit.**

16.4. The insured person **is not entitled to cash benefits** under the supplementary insurance.

16.5. The care organiser shall organise the insured person's care at a healthcare provider contracted by it.

17. Waiting period

17.1. The insurer **applies a waiting period of 60 days** to supplementary insurance. The waiting period begins on the date of commencement of risk coverage under the supplementary insurance.

17.2. **The insurer also applies the following service restrictions:**
If the insured person registers at the place of risk coverage after the commencement of risk coverage, the insurer shall provide services to the insured person 60 days after registration at the place of risk coverage. In all other cases, the insurer shall provide the service after 60 days have elapsed since the commencement of risk coverage.

During the waiting period and the period of service restriction, the care organiser shall not organise care for the insured person.

18. Conditions for modification or cancellation of care organised by the care organiser by the insured person

18.1. The insured person may modify or cancel an already agreed appointment no later than 2 working days before the date of the examination.

18.2. If the insured person
a) cancels the care later than this, or
b) does not appear at the service provider at the pre-arranged time,
it shall be deemed as if the insured person had used the service, so if the service provider invoices the care organiser for the unused service, the cost thereof may be deducted from the relevant annual service budget (limit).

18.3. The insured person may request that the unused service be re-organised.

19. Obligation to prevent and mitigate damage

The policyholder and the insured person are obliged to prevent and mitigate damage, i.e. the insured event, in a manner that can generally be expected in the given situation.

20. Exemption of the insurer

In the following cases, the insured event occurs, but the insurer is exempt from its obligation to perform and therefore does not provide any services.

The insurer shall be exempt from its obligation to provide services if the insured event is related to an injury, illness or accident of the insured person which
a) the insured person caused to themselves intentionally or through gross negligence, including acts committed while in a state of mental disorder,
b) was caused unlawfully and intentionally or through gross negligence by the insured person, the policyholder or a relative living in the same household as the policyholder or the insured person.

The above provisions shall also apply to breaches of the obligation to prevent and mitigate damage.

The insurer shall also be exempt from its obligation to provide benefits if the insured event is related to an injury, illness or accident of the insured person which is causally related to the insured person's
a) intoxication or under the influence of narcotics or other intoxicating substances,
b) mental or consciousness disorder, or suicide or attempted suicide committed within two years of the conclusion of the contract
c) or in connection with the insured person being subject to sanctions.

The insurer shall not be exempt from liability if the insured person, exercising his or her legal right of disposal, does not consent to medical intervention.

21. Refund of insurance premium

If the supplementary insurance is terminated, the insurer shall refund to the policyholder the insurance premium that the policyholder paid in advance to cover the risk period after the supplementary insurance expires. The refund will be credited to the contract fee, transferred or sent by post within 60 days of the expiry of the supplementary insurance.

22. Limitation period

Claims arising from supplementary insurance shall become time-barred 5 years after they become due. The limitation period shall not be interrupted by a written request for payment of the claim.

23. Due date

The date of maturity of a claim for supplementary insurance benefits is the date on which the insured person reports the insured event to the benefits administrator by telephone.

The date of maturity of other claims is the date on which the circumstances giving rise to the claim occur.

24. Data processing

24.1. In order to provide the service, the insurer uses a care organiser, who is also entitled to involve additional subcontractors. The care organiser and its contributors act as data processors for the insurer during the organisation of care and the provision of care based on this, and process personal data in accordance with the insurer's instructions. The healthcare provider actually providing the healthcare services processes the data obtained in the course of providing the healthcare services and arising in connection therewith as an independent data controller, in accordance with its own data processing policy. The insurer entrusts Teladoc Hungary Kft. with the performance of care coordination tasks.

24.2. If an insured person entitled to services wishes to report their claim for services by telephone, they must expressly consent to the processing of the necessary health data during the reporting process.

If the insured person does not consent to the processing of their health data when reporting their claim for the service by telephone, the insurer will not be able to provide insurance services to the insured person under the present conditions, and therefore the care organiser will not organise the requested care for the insured person.

The insured person has the right to withdraw their consent, but this does not affect the lawfulness of data processing prior to the withdrawal.
The insured person may exercise their right to withdraw their consent by sending a letter addressed to the insurer's data protection officer at the insurer's registered office (mailing address: 1087 Budapest, Könyves Kálmán krt. 48-52., Strategic and General Administration Division, Compliance Department or www.allianz.hu data protection interface) after identification. The insurer uses the following data for identification: name, contract number and/or claim number, date and place of birth, mother's name.

24.3. In order to provide the service, the insurer shall forward the following data relating to the insured person to the care organiser acting as data processor:
– the contract number of the basic insurance contract,
– the start date of the supplementary insurance,
– date of premium settlement,
– the names of the policyholder and the insured person,

– the name of the insured person's mother,
– date of birth of the insured person,
– code of the insured partner,
– address of the insured person (place of risk),
– e-mail address of the insured person,
– mobile phone number of the insured person.

In connection with the provision of services, the insurer processes the following data in addition to the above:
– data generated during the request for healthcare services: date of request, method of request, content of request (voice recording in the case of telephone requests), data content of documents provided during the request (health data),
– data generated during the organisation of care: appointment booking, appointment confirmation, type of care, reasons for care, any cancellations, data generated in connection with non-attendance,
– data generated during the financial settlement of the services provided: amount of coverage, fee for the care provided, currently available coverage amount.

24.4. The insurer processes personal data in connection with the performance of the contract and the provision of services, during which it is entitled to engage the cooperation of authorised third parties and to transfer the data necessary for the performance of the task to the party performing the outsourced activity. The care organiser, as an outsourced activity provider, continuously stores the current database of the contracting party and the insured persons using the insurance service, and compares the data provided by the insured person with this database when the insured person makes a claim in order to identify the insured person and their entitlement to care.

24.5. At the request of the policyholder and the insured person, the care provider shall provide information on the healthcare providers who participated in the insurance service for the insured person.

24.6. The insured person acknowledges that if, when using the healthcare services organised by the care organiser, they refuse to transfer their medical documentation to the care organiser, they shall be obliged to pay the fee for the service used themselves.

24.7. Detailed information on the processing of personal data can be found in the insurer's Data Processing and Customer Information and Contract Terms Supplement document, which is available on the data protection page at www.allianz.hu.

25. Rules on termination

25.1. Termination of supplementary insurance
a) Upon termination of the Basic Insurance, the Supplementary Insurance shall also terminate.
b) Supplementary insurance shall also terminate if all insured persons covered by the contract reach the age of 70. reaches the age of 70. Effective date of termination: In the event of notification by the policyholder or the insured person that the insured persons have reached the age of 70, the effective date of termination shall be the date on which the last insured person reaches the age of 70.
c) The supplementary insurance shall also terminate if all insured persons covered by the contract all insured persons covered by the contract die. Effective date of termination: In the event of notification of the death of the insured persons, the date of death of the last insured person.
d) Upon expiry of the one-year fixed term, if either party indicates in accordance with these Terms and Conditions that it does not wish to extend the term.
e) The policyholder may terminate this supplementary insurance – while maintaining the Basic Insurance – in writing with 30 days' notice to the anniversary date of the Basic Insurance. The termination shall take effect on the anniversary date of the Basic Insurance.
f) Further provisions regarding the termination of supplementary insurance due to loss of interest or impossibility are contained in Allianz MyHome Insurance Benefits Guide, I. General Insurance Terms and Conditions, Section 6.

25.2. **Termination of risk coverage for individual insured persons:**
a) Supplementary insurance shall terminate for the insured person concerned on the day on which he or she reaches the age of 70.
b) Supplementary insurance shall terminate in respect of the insured person upon the death of the insured person. The termination shall take effect on the date of death of the insured person.
c) Supplementary insurance shall terminate with respect to the natural person named as the insured in the insurance contract (offer, policy) if the address on that person's residence card changes and no longer corresponds to the place of risk coverage under the Basic Insurance.

26. Deviation from the Civil Code and previous contractual practice

a) **These Terms and Conditions differ from the Civil Code in the following respects:**
– it is not possible to designate or maintain the

designation of a beneficiary for the provision of this supplementary insurance;
- The supplementary insurance policy concluded simultaneously with the basic insurance policy shall come into effect at 00:00 hours on the day following the submission of the offer.
- in the case of supplementary insurance concluded simultaneously with the Basic Insurance Contract, the risk coverage shall commence at 00:00 on the day following the submission of the offer;
- supplementary insurance concluded during the term of the Basic Insurance shall come into effect at 00:00 on the day following the date on which the insurer receives the declaration of conclusion of the supplementary insurance;
- in the case of supplementary insurance taken out during the term of the Basic Insurance, the risk coverage shall commence at the time specified in the declaration of conclusion of the supplementary insurance, or, in the absence thereof, at 00:00 on the day following the receipt of the declaration by the insurer.
- the insurer shall provide the service in the form of payment of the sum insured,
- the total value of services available within the insurance year is limited (annual limit) and is determined jointly for the insured persons covered by the supplementary insurance,
- The supplementary insurance is concluded for a fixed term of one year, which shall expire upon expiry of the fixed term, unless either party indicates in accordance with these Terms and Conditions that it does not wish to extend the term.

b) **These Terms and Conditions differ from the insurer's previous contractual practice in the following respects:**
- the insurer did not previously sell high-value diagnostic insurance in connection with the Basic Insurance, which was previously only available for health and life insurance products,
- the condition for using the service is that the insured person must notify the care provider in advance of their need for the service,
- the insurer applies a waiting period and service restrictions,
- the limitation period is not interrupted by a written request for payment of the claim,
- If the person entitled to use the service is a minor, proof of the legal representative's authority to act on their behalf is also required, and the insurer or care provider may request the relevant documents.

Supplementary legal protection insurance

Special terms and conditions

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Customer information

Within the framework of supplementary legal protection insurance related to your home (hereinafter: legal protection insurance), in connection with the enforcement of certain claims for damages, contractual claims, property claims or legal infringements related to your participation in the online space, we provide legal advice via our external service partner

- **we provide legal advice by telephone or contribute to your legal fees**, and
- if necessary, we will recommend a lawyer.

All of the above services are provided in cooperation with **our external service provider, LegitiMo Jogvédelmi Biztosító Zrt.** (1087 Budapest, Hungária körút 30. A. ép. 8. em.).

Of the above services, telephone legal advice is available seven days a week between 9 a.m. and 5 p.m. exclusively by telephone, on the standard domestic rate number +36 1 710 1130 after prior telephone identification.
The telephone legal advice service can be used for an unlimited number of insured events within the insurance period, with no limit on the number of occasions.

In addition, you also have the option of using another legal representative of your choice. In such cases, we will pay you a maximum of HUF 10,000 + VAT per insured event, but no more than HUF 100,000 + VAT per insurance year.
We will contribute to your legal fees if you seek advice not from us by telephone, but from your own solicitor or a solicitor recommended by us.
We will contribute to your legal fees no more than once per insured event.

Details of the individual services can be found in this document under the heading „Terms and Conditions".

Terms and Conditions

These Terms and Conditions contain the provisions applicable to the Supplementary Legal Protection Insurance related to the Allianz MyHome insurance (hereinafter: Basic Insurance) concluded between Allianz Hungária Zrt. (hereinafter: Insurer) and the Policyholder.

In matters not regulated by these Supplementary Legal Protection Insurance Terms and Conditions, the terms and conditions of the Basic Insurance shall apply.

In the event of any discrepancy between these Supplementary Legal Protection Insurance Terms and Conditions and the terms and conditions of the Basic Insurance, these terms and conditions shall prevail.

The insurer's key details, the provisions of applicable law, information relating to the sale of insurance products (advice, remuneration), the provisions of the insurance contract relating to the processing of personal data, the rules relating to insurance secrecy, information on complaint handling, information on distance selling, the rules on limitation periods and the rules on electronic contracting are contained in a separate document accompanying the Basic Insurance Policy („Supplement to the Data Processing and Customer Information and Contract Terms and Conditions").

1. Contracting parties

1.1. **Contracting party**
The contracting party is the same as the contracting party of the Basic Insurance.

1.2. **Insured**
The policyholder is considered the insured party, and the policyholder's close relatives who are permanently registered at the place of risk according to their address card are also considered insured parties.
The insured person is entitled to the insurer's services.

1.3. **Insurer**
The insurer is Allianz Hungária Zrt., which **provides all of the insurance services** specified in this Legal Protection Insurance **through its service provider partner**.

1.4. **Insurer's service provider partner**
The insurer's service provider partner is LegitiMo Jogvédelmi Biztosító Zrt.
The service provider partner is responsible for providing

insurance services, including making cash payments, in the manner and in the cases specified in these terms and conditions.

Service provider contact details:
Registered office: 1087 Budapest, Hungária krt. 30. A ép. 8. em.
Postal address: 1428 Budapest, Pf.: 9.
Telephone number: +36 1 486 3600
Fax number: +36 1 486 3601
E-mail address: iinfo@legitimo.hu

2. Insured event

The prerequisite for the provision of insurance services is that an insured event occurs.

An insured event is deemed to have occurred if the insured person requires legal advice on the following matters:

a) Compensation for damages: Damage to personality, physical integrity or property related to the use of the insured property, as a result of which the insured may be entitled to compensation for damages outside the scope of the contract.
b) Contractual legal protection: Breach of contract in connection with the insured property or the property located therein or thereon, as well as the need for legal advice prior to the conclusion of the contract.
c) Real estate legal protection: Legal disputes arising from the insured property, or from its use or interference with its use.
d) Online legal protection: The occurrence of a personal or property-related legal infringement suffered directly during participation in the online space.

The insurer shall only provide services in connection with insured events occurring under the Basic Insurance and this Supplementary Legal Protection Insurance.

The commencement of the risk coverage of the legal protection insurance:

– coincides with the commencement of risk coverage under the Basic Insurance if it was concluded at the same time as the Basic Insurance contract,
– if this Supplementary Insurance is concluded subsequently to an existing Basic Insurance contract, it shall commence at 00:00 hours on the day following the receipt of the declaration of conclusion of the Supplementary Insurance by the Insurer.

3. Date of occurrence of the insured event

a) **legal protection for compensation:** the date of occurrence of the damage.
b) **contractual legal protection:** the date of the actual or alleged breach of contract the date of the event or the need for legal advice prior to the conclusion of the contract.
c) **property law protection:** the date of the occurrence of a legal infringement related to the use of the insured property, or in the event of a legal dispute arising from the disruption of its use, the date of the occurrence of the disruptive behaviour.
d) **online legal protection:** the date of the occurrence of conduct violating personal rights or property rights during participation in the online space.

4. Territorial and temporal scope, jurisdiction

4.1. **The territorial scope only applies to insured events that occurred in Hungary and which fall under the jurisdiction of Hungarian courts.**

4.2. This supplementary insurance is of indefinite duration.

5. Services of the insurer

The insurance services are as follows:

5.1. **Legal advice by telephone**
In the event of an insured event, **the insurer's service partner, LegitiMo Jogvédelmi Biztosító Zrt.**, provides telephone legal advice. **The telephone legal advice service can be used for an unlimited number of insured events during the insurance period, with no limit on the number of times it can be used.**

This legal advice is available every day of the week **between 9 a.m. and 5 p.m.**, exclusively by telephone, **on the standard domestic telephone number +36 1 710 1130**, following prior identification by telephone.

5.2. **Contribution to legal fees**
If the insured person **seeks advice by telephone not from the insurer's service provider partner** but from their own solicitor or another solicitor recommended by the insurer's service provider partner, we will contribute to the solicitor's fees. We will contribute to these solicitor's fees no more than once per insured event.

An insured event is also considered to be a loss event if it consists of several temporally related events that occurred for the same reason; – affect several persons.

The insurance provider's partner shall reimburse the insured person for the fees and costs of a freely chosen legal representative, as evidenced by an invoice, up to a maximum of HUF 10,000 + VAT per insured event, but not exceeding HUF 100,000 + VAT per insurance year.

The insurance year is the period from the anniversary of the insurance to the anniversary of the insurance.

The lawyer is appointed by the insured person. The lawyer is accountable to the insured person for his or her work; the insurer and the insurer's service provider partner are not liable for this.

6. Inception date

The insurance provider's partner provides the telephone legal advice service immediately after the telephone call. If the insurance provider's partner is unable to respond immediately, they will call the insured person back within one day.

The insurance provider's partner shall pay the contribution to the lawyer's fees within 30 days of receiving the invoice. VAT shall only be reimbursed if the insured person is not entitled to claim it back.

7. Areas of insurance coverage

The insurer provides insurance services through its service provider partner in the following areas:

a) **Legal protection for compensation:** telephone legal advice regarding the enforcement of claims for personal injury, property damage and damages related to the insured property or its use against the party causing the damage, and, if necessary, referral to a solicitor for legal representation in litigation.
b) **contractual legal protection:** breach of contract relating to the insured property or to property contained therein, or breach of contract prior to the conclusion of such contract; telephone legal advice on rights, facts and circumstances that deserve special attention from a legal perspective; as well as information on warranty, consumer or other rights, the possibility of enforcing them and the procedural process in legal disputes arising after a breach of contract, and, if necessary, a recommendation for a lawyer to provide legal representation in litigation or out-of-court proceedings.
c) **Real estate legal protection:** use of the insured real estate Legal advice by telephone regarding the enforcement of legal claims arising from the disruption of use, and, if necessary, referral to a solicitor for legal representation in litigation.
d) **Legal protection related to online space:** legal advice by telephone regarding the enforcement of personal rights or property damages directly suffered during participation in online space against the perpetrator, as well as general legal procedures and recommended actions in such cases. if necessary, recommendation of a lawyer to provide legal representation in litigation.

The telephone legal advice service provided by the insurance provider's partner refers to the insurance provider's partner's verbal opinion, provided by telephone, regarding the possible solutions to an insured event. The insurance provider's partner provides the legal advice service based on the information provided by the policyholder or the insured. The insurer and its service provider partner shall not be held financially or legally liable if

- **the information provided by the policyholder or the insured is incomplete or contradictory,**
- **the relevant legal provisions are contradictory or unclear,**
- **the legal dispute can be decided at its discretion,**
- **unfavourable business, economic or legal circumstances arise independently of the insurer, and the insured or policyholder suffers damage in connection with these circumstances.**

In such circumstances, the insurer or the insurer's service provider expressly excludes liability for legal advice, which is brought to the attention of the policyholder and the insured by this provision.

8. Obligations of the insured person in connection with the notification of an insured event

All claims for services must be reported to the insurer's service provider partner, LegitiMo Jogvédelmi Biztosító Zrt., including cases where the insured person does not seek legal advice from the insurer's service provider partner but wishes to use a lawyer of their own choosing.

During the telephone legal consultation provided by the insurer's partner, the insured person is obliged to report the insured event no later than 15 days after it occurs. to the insurer's service provider partner. The insurer and its service provider partner shall not be liable for any damage resulting from a delay in reporting. When reporting an insured event, the insured person is obliged to cooperate with the insurer's service provider partner. In order for the insurer's service partner to be able to provide professionally sound legal information in connection with insured events, the insured person is obliged to provide detailed information and evidence available to them in connection with the insured event, as well as the circumstances surrounding the occurrence of the insured event.

In the event of legal advice provided by a legal representative freely chosen by the insured, the insurance provider's partner shall be entitled to request and verify the contract of engagement concluded with the lawyer, the power of attorney given to the lawyer, and the agreement on the termination of the contract of mandate, the statement of facts, the invoice for the solicitor's fees, and the receipt for the payment of the solicitor's fees. If the insured fails to fulfil these obligations and, as a result, circumstances relevant to the assessment of the insured event cannot be ascertained, the insurer shall be released

from its obligation to provide the service, or the insurer – through its service partner – shall be entitled to reduce the insurance benefit to the extent that the breach of obligation affected the extent of the service obligation.

Of the documents listed, the insurer may only request, through its service provider partner, the presentation of documents and invoices necessary to determine the occurrence of the insured event and the extent of the service to be provided.

Several events occurring for the same reason, in close succession and affecting the same insurance contract shall be considered as one insured event, regardless of whether the same insured event affects one or more insured persons. In such cases, the date of the first event shall be the date of the insured event.

Reporting the insured event to the insurer (the insurer's service provider partner) does not exempt the insured from their legal or contractual obligations to report (damages) to third parties, in particular other insurers.

The insured person is obliged to refrain from any action that unnecessarily increases the legal protection costs associated with this legal protection insurance. The insured person is obliged to obtain the prior written consent of the insurer's service provider for any important measures that affect or may affect the insurer's service provider's obligations. In the absence of prior written consent, the insurer is entitled, through its service provider partner, to refuse to bear the costs incurred in this way.

9. Legal representation, conflict of interest

The insured person may freely choose their legal representative in court or administrative proceedings related to insured events covered by this Supplementary Legal Protection Insurance, or in proceedings preceding the commencement of such proceedings, in order to facilitate the avoidance of proceedings. However, the insured person is obliged to consult with the insurer's service provider partner.
the method of legal representation in the event of an insured event, except in cases where delay would result in immediate damage. If the insured person intentionally breaches this obligation, the insurer's service partner shall be entitled to reduce the service to the extent that the breach of obligation affected the extent of the service obligation.

If the insured person does not exercise their right of free choice, the insurer's service partner shall provide legal representation in the insured person's interest through its own employee or by **recommending a lawyer** whose **invoiced fees and costs shall be covered** by the insurer – through its service provider partner – **up to a maximum of HUF 10,000 + VAT per insured event, but not exceeding HUF 100,000 + VAT per insurance year**.
The insurer shall cover **the fees and costs of the legal representative freely chosen by the insured, as evidenced by an invoice**, through its service provider partner, in the amount specified in the applicable legislation on lawyers' fees and costs, **up to a maximum of HUF 10, 000 + VAT per insured event, but not exceeding HUF 100,000 + VAT per insurance year**. The insured person shall be obliged to release their legal representative from their confidentiality obligation towards the insurer in the contract of engagement concluded with them, pursuant to Section 12(1) of Act LXXVIII of 2017 on the activities of lawyers from his/her confidentiality obligation towards the insurer and to instruct him/her to keep the insurer informed of the progress of the case.

In order to protect their legal interests, the insured may freely choose their legal representative even if there is a conflict of interest on the part of the insurer. If there is a conflict of interest, the insurer is obliged to immediately notify the insured of this fact through its service provider partner and inform them of their right to freely choose a solicitor. In the event of a conflict of interest, the insured person shall only be subject to the obligation to provide preliminary information and notification in relation to the insured event with regard to their authorised legal representative. In such cases, the insured person is only obliged to report the occurrence of the insured event, the details of their legal representative and the fact that they have given power of attorney to their legal representative to the insurer's service provider partner.
In all cases, the insured shall establish a contractual relationship with the legal representative. The legal representative shall be directly responsible to the insured for the performance of his or her duties. The insurer or the insurer's service provider shall not be liable for the activities or actions of the legal representative. If the insured person fails to cooperate with the legal representative appointed by him/her, thereby preventing the successful enforcement of claims or legal defence, the insurer shall be exempt from the obligation to provide the service. The insurer may, through its service provider partner, represent the insured on the basis of a power of attorney and accept money on behalf of the insured, which it is obliged to forward to the insured within 15 days. The insurer shall keep the insured informed of the status of the case through its service provider partner. The insured may only take measures that may affect the insurer's obligation to provide services with the insurer's prior written consent. In the absence of prior consent, the insurer shall be entitled, through its service provider partner, to refuse to bear such costs. The insurer shall be entitled, through its service provider partner, to examine the possibility of amicable settlement of legal disputes, in particular out-of-court settlements.

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If this is possible, the insurer shall attempt to reach an agreement and may not refuse to consent to the out-of-court settlement of the legal dispute without sufficient grounds.

10. Conciliation procedure

If a disagreement arises between the insured and the insurer in connection with the legal advisory services listed above, the insured is entitled to freely engage a solicitor in order to obtain impartial legal advice and to seek advice from him/her within the scope of the insurance cover (conciliation procedure). The insured must notify the insurer's service partner within 14 days of the disagreement arising who will represent them in the conciliation procedure. The insurer's service partner shall then instruct its own legal representative to initiate the conciliation procedure within a further 14 days.

If both legal representatives reach the same opinion during the conciliation procedure, this decision shall be binding on both the insured person and the insurer.
If the insurer's opinion is confirmed, the insured may seek legal advice from a legal representative of their choice at their own expense. The same procedure applies if the appointed legal representatives fail to reach an agreement or are unable to make a decision within four weeks.
If the outcome of the conciliation procedure is favourable to the insured, the costs of the conciliation procedure and thus also the costs of the legal representatives shall be borne by the insurer through its service provider partner. Otherwise, and if the legal representatives fail to reach an agreement or are unable to make a decision at all, each party shall bear its own costs.

If the legal representatives of the parties fail to reach agreement during the conciliation procedure, the insured person shall have the option of obtaining legal advice from a freely chosen legal representative. The insurer's service partner shall be obliged to inform the insured person of this in writing. If the advice given by the freely chosen legal representative proves to be correct, the insurer – through its service provider partner – shall be obliged to reimburse the costs retrospectively in accordance with the general rules, **i.e. it shall reimburse the insured person for the fees and costs of the freely chosen legal representative, as evidenced by an invoice, up to a maximum of HUF 10,000 + VAT per insured event, but not exceeding HUF 100, 000 + VAT per insurance year**.

11. Special cases of insurance services

a) Partial legal protection: If the costs to be paid in connection with the protection of the insured's legitimate interests relate to legal disputes for which legal protection is only partially available, the insurer shall, through its service partner, only bear those costs that it would have to bear even without taking into account claims not covered by the insurance protection. If the obligation to perform cannot be determined in this way, the insurer shall bear the costs, through its service partner, only in proportion to the value of the insured and uninsured claims. In the case of criminal and misdemeanour proceedings, if the subject matter of the proceedings consists of several infringements and are not covered by this legal protection insurance, the insurer shall bear the costs only in respect of the infringement(s) covered by the insurance.
b) Value added tax: The insurer's services do not cover the payment of value added tax included in the costs incurred in the course of the insured's legal protection, provided that the insured is entitled to deduct or reclaim it from their tax.

12. Further exclusions

In addition to the exclusions specified in the Basic Insurance, this Supplementary Legal Protection Insurance does not cover:
a) family law disputes,
b) tax law disputes,
c) copyright disputes,
d) litigious and non-litigious matters against the insurer,
e) litigious and non-litigious matters against LegitiMo Jogvédelmi Biztosító Zrt. or its subsidiaries,
f) cases involving terrorism, preventive measures due to terrorism, war, civil war, hostile acts, subversion, internal unrest, strikes, earthquakes, nuclear or genetic damage, natural disasters, mining damage;
g) fines and penalties (the insurer shall not pay fines or penalties on behalf of the insured); compensation or claims for which the insured is liable;
h) claims for damages against the insured, claims, claims for damages, and the insured's obligation to fulfil the obligations arising from the contract concluded by him/her (e.g. parking surcharge or claims against him/her arising from the insured's failure to pay for the service used);
i) in proceedings initiated in connection with the insured event, fines imposed on the insured or their legal representative for malicious litigation or omission, or the payment of additional costs incurred in connection with such conduct;
j) bankruptcy, liquidation, winding-up proceedings, asset settlement, compulsory cancellation and legality supervision proceedings;
k) the enforcement of legal claims arising in connection

with the insured events specified in this contract in litigation and out-of-court proceedings, as well as the costs necessary for this.

l) **contractual disputes where the other party does not have its registered office, place of business or branch in Hungary.**

13. Supplementary insurance premium

The premium for supplementary insurance shall be paid in Hungarian forints together with the premium for basic insurance and at the same frequency as the premium for basic insurance.

The supplementary insurance premium is payable to the insurer from the first day of the supplementary insurance risk coverage.

14. Rules of indexation

In the case of this supplementary insurance, the insurer does not apply indexation.

15. Termination of the contract

15.1. Upon termination of the Basic Insurance, this Supplementary Legal Protection Insurance shall also terminate.

15.2. This Supplementary Legal Protection Insurance can only be terminated together with the Basic Insurance. Notwithstanding the above, the insurer may also terminate this Supplementary Legal Protection Insurance separately if the contract for the provision of insurance services with its service partner specified in Section 1.4, LegitiMo Jogvédelmi Biztosító Zrt. is terminated. In this case, the notice period for termination communicated by the insurer shall be 30 days.

Allianz Medical Call Centre service

Special terms and conditions

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1. Allianz Hungária Zrt. (hereinafter: insurer) provides a 24-hour medical call centre service for Allianz MyHome insurance policies through its healthcare service partner (Teladoc Hungary Kft., hereinafter: service provider) on the basis of these terms and conditions.
The present terms and conditions apply to the Allianz Medical Call Centre service.

Allianz Medical Call Centre service

2. **The medical call centre service provides round-the-clock medical advice and can be reached on 06-1-510-0522.**
The insurer provides this service without charging any additional fees.

Using the service

3. The Allianz Medical Call Centre service can be accessed by calling the service provider's toll-free number.

The Allianz Medical Call Centre service is also available on the www.allianz.hu website, where those eligible for the service can submit their questions in writing.

The service provider will send the answer to the e-mail address provided by the person entitled to the service within 24 hours of the question being asked.

4. Allianz Ott-honom home insurance policyholders and insured persons are eligible to use the service, provided that they identify themselves with the identification data specified below.

Data required for identification:
- the contract number of the Allianz MyHome insurance policy,
- the name of the policyholder of the Allianz MyHome insurance policy,
- the date of birth of the policyholder of the Allianz MyHome insurance policy,

When using the service, the service provider always identifies the customer.

The service provider acts as an independent data controller when providing the service; the insurer does not receive any information about the calls or their content.

5. The Allianz Medical Call Centre can be called 24 hours a day, every day of the year, where qualified, practising doctors provide information on the following issues:
a) questions related to lifestyle, health maintenance and the interpretation of medical documentation;
b) information on the composition, side effects, applicability, substitutability and price of medicines;
c) information on medical, paediatric and dental emergency services;
d) information on on-call pharmacies;
e) information on the availability of healthcare institutions.

6. The service provider records incoming telephone calls in order to perform the insurance service in accordance with the insurance contract and to provide the insurer with information about the activities it has performed.

Exclusions

7. The following cases are not considered insured events, therefore the insurer shall not provide insurance services:
a) making a diagnosis based on the insured person's complaints,
b) organisation of medical care.

Other provisions

8. The information provided by the Allianz Medical Call Centre service is for informational purposes only and does not replace a personal medical examination.

9. The insurer may terminate the Allianz Medical Call Centre service provided by the service provider at any time, unilaterally and without justification. With regard to the termination of the service, the policyholder and insured person of Allianz MyHome insurance may not assert any claims against the insurer due to the termination of the service.

10. The insurer shall not be liable for the accuracy of the information provided within the framework of the medical Call Centre service, its reliability, its misuse or misinterpretation, or for any financial or non-financial damages resulting from the failure to provide the requested information, or its delayed delivery, or from incorrect or erroneous medical opinions.

11. **By signing the offer, the policyholder of Allianz MyHome insurance declares that they wish to use the Allianz Medical Call Centre service provided by Allianz Hungária Zrt.'s contracted partner, Teladoc Hungary Kft.**