



# **POLISA ZDROWIE**

## **General Individual Insurance Terms**

### **OWU/02/2019**

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Information pursuant to Art. 17 of the Polish Act dated September 11, 2015 on insurance and reinsurance activities (Journal of Laws item 1844)

The following sections indicate the numbers of provisions of the General Terms and Conditions of Insurance defining the matters indicated in the names of these sections:

| Item | section  | provisions of the General Terms and Conditions of Insurance   |
|------|--|---|
| 1.   | premises for the payment of compensation and other benefits  | § 2 passages 2, 3, 8, 13, 15, 18, 19, 20, 21;<br>§ 3;<br>§ 4 passage 2;<br>§ 6;<br>§ 8 passage 2;<br>§ 12 passages 1-4, |
| 2.   | limitations and exclusions of liability of the insurance company entitling to refuse to pay the compensation and other benefits or reduce them | § 2 point. 2, 15, 19, 21;<br>§ 3;<br>§ 4 passage 2;<br>§ 5;<br>§ 6;<br>§ 8 passage 2;<br>§ 12 passages 1-4;             |

## § 1. General Provisions

1. Pursuant to these General Terms of Insurance (hereinafter referred to as OWU), Towarzystwo Ubezpieczeń ZDROWIE S.A. based in Gdynia, Polish National Court Register (KRS) number 0000362027 (hereinafter referred to as the Insurance Company) concludes health insurance agreements.
2. The insurance agreement may be concluded for the benefit of the Insured, defined in the insurance agreement or in the policy confirming that the insurance agreement was concluded, who do not need to be indicated by name in the agreement.
3. In the case of agreements concluded for the benefit of a third party, the Insuring Party is obliged to provide these OWU, the Catalogue of Benefits as well as the terms of agreement for a given insurance to all interested parties before this interested party concludes the insurance agreement as the Insured Party or before this interested party expresses the consent to be provided insurance protection or before this interested party expresses the consent to finance the cost of the insurance contribution, whichever of these events takes place sooner.
4. Provisions regarding the Insuring Party in the agreement concluded for the benefit of a third party apply accordingly to the Insured Party.
5. After the acceptance of the parties to the insurance agreement, additional provisions may be introduced which differ from these OWU, which prevail over the provisions of OWU. The additional provisions need to be made in writing in order to be valid.
6. In any cases not regulated in these OWU, the absolutely binding regulations of the Polish law apply.

### What do the definitions in this document mean?

## § 2. General definitions

The notions used in these OWU are defined as follows:

- 1) **Child** – own or adopted child of the Insured Party, age up to 18, or up to 26 if the child forms a joint household with the Insured Party;
- 2) **Upper limit of liability - GGO** - limit of benefits indicated for each medical service, expressed in PLN and/or being a percentage of the insurance sum specified in the Catalogue of Benefits, paid to the Insured Party, a person or an entity indicated by the Insured Party in the case of an event covered by insurance protection in the insurance option used by a given Insured Party. The Insured Party is entitled to the benefit only in the case of events covered by insurance protection in the insurance option selected by the Insuring Party;
- 3) **24 h Helpline** - a service active 24 hours a day, 7 days a week thanks to which the Insured Party may make an appointment or confirm the date of medical appointments, diagnostic tests and treatments, namely perform a medical benefit;
- 4) **Catalogue of Benefits** - a list of benefits to which the Insured Party is entitled in the case of an event covered by insurance protection as part of the selected insurance option, constituting Appendix No 1 to these OWU;
- 5) **Customer** – a natural person being the Insuring Party, the Insured Party, the beneficiary or the authorized party from the insurance agreement concluded with the Insurance Company;
- 6) **Appeal** – a request addressed to the Management of the Insurance Company by its Customer in which the Customer submits objections regarding the examination of a Complaint;
- 7) **Partner** - an adult not related with the Insured Party forming a joint household with the Insured Party
- 8) **Medical Facility/Institution** - a healthcare entity acting according to the law, providing medical services on the territory of the Republic of Poland;
- 9) **PLN** - Polish zloty, being the basic monetary unit in the Republic of Poland;
- 10) **Policy** – a document confirming the conclusion of an insurance agreement between the Insuring Party and the Insurance Company;
- 11) **Complaint** – a request addressed to the Insurance Company by its Customer in which the Customer submits objections regarding services provided by the Insurance Company;
- 12) **Family** – two adults in a marriage or in a partnership, or two adults in a marriage or in a partnership and their own children of at least one of these persons or adopted by at least one of these persons, or one adult with their own children or adopted children; a family is also a foster family, related or not related, except for not related professional foster families;
- 13) **Policy year** - subsequent 12 months from the beginning of insurance protection covering a given scope of Medical Services;
- 14) **Grievance** – an intervention from the Customer or the Insuring Party not being a natural person regarding irregularities in the activities of the Insurance Company or entities cooperating with the Insurance Company not related to concluding or executing a specific insurance agreement;
- 15) **Insurance sum** - the liability limit of the Insurance Company on account of insurance events, completed without the intermediation of the Helpline 24 h, specified for a given insurance option;
- 16) **Durable medium** – a medium allowing the user to store information addressed to the user in a manner enabling access to it for the period appropriate = for preparing this information and making it possible to recover the stored information in an unchanged form;
- 17) **Insuring Party** – a natural person, a legal person or an organizational unit without legal personality, concluding the insurance agreement and obliged to pay the contribution;
- 18) **Insured Party/Person** – a natural person for the benefit of whom the insurance agreement was concluded;

- 19) **Medical service** – medical advice, diagnostic tests, treatments: surgeries, care, rehabilitation and other actions, including the purchase of products and materials used to preserve, care for and improve health described in the Catalogue of Benefits for a given insurance option which were conducted or purchased throughout the insurance protection;
- 20) **Insurance Option** - scope of benefits selected by the Insuring Party to which the Insured Party is entitled as part of the available insurance protection;
- 21) **Insurance event** - a disease of the Insured Party requiring the medical institution to perform a medical service during the insurance protection used to restore, preserve, improve health or prevent the deterioration of the health condition;

### § 3. Detailed definitions of benefits

As part of insurance protection, in the case of an insurance event, depending on the selected insurance option, the Insured Party may be entitled to the following benefits:

- 1) **Medical benefit** - a Medical Service granted to the Insured Party throughout the insurance protection specified in the Catalogue of Benefits for the selected insurance option the date and place of performance of which within the territory of the Republic of Poland is indicated by a consultant of the Helpline 24 h, or the performance of which is confirmed via the telephone to the Insured Party or directly to the employee of the medical institution by the consultant of the Helpline 24 h;
- 2) **Cash/financial benefit** - a benefit in the amount limited by GGO, paid in PLN to the Insured Party, to a person or an entity indicated by the Insured Party on account of the occurrence of an Insurance Event in the life of the Insured Party throughout the insurance protection, as specified in the Catalogue of Benefits for the selected insurance option related to the right of the Insured Party, the person or the entity indicated by the Insured Party to a given cash benefit;

#### *What do I gain from the insurance?*

### § 4. Subject and scope of insurance

1. The subject of the insurance is the Insured Party's health.
2. The insurance protection covers the right to the following benefits which are granted if it is justified by the health condition of the Insured Party:
  - a. **medical**, namely providing the Insured Party with non-cash medical services, specified in the Catalogue of Benefits for the insurance option selected by the Insuring Party, in Medical Institutions indicated by the Consultant of the Helpline 24 h;
  - b. **cash**, namely the payment of a benefit in PLN on account of the occurrence of an insurance

event in the life of the Insured Party specified in the selected option.

#### *When is it impossible to use medical services?*

### § 5. Limitations of liability

1. The Insurance Company is not liable for insurance events that occurred during the grace period.
2. The grace period is a period in which the Insured Party is not entitled to a benefit defined in the selected insurance option, beginning on the selected starting date of insurance protection for a given Insured Party,
3. The grace period for particular benefits is described in the Catalogue of Benefits. The grace period is not valid in the case of the continuation of the insurance agreement in the subsequent year in the same or a smaller extent of protection.
4. If the Insuring Party does not pay the full instalment of contributions for all Insured Parties within the deadline, the rights of the Insured Parties to use medical benefits and cash benefits in the on-line mode are suspended until the arrears are paid in full. Next day after the arrears are paid, the rights of the Insured Parties to use medical benefits and cash benefits in the on-line mode will be restored.
5. The Insurance Company is not liable for insurance events caused by:
  - a. the introduction of and the occurrence of state of emergency, martial law, war or hostilities;
  - b. a physical or a mental defect disclosed before the 1st year of life resulting from genetic diseases, prematurity or perinatal trauma;
  - c. the Insured Party's consumption of alcohol, intoxicants or drugs;
  - d. the treatment and diagnosis of infertility;
  - e. a health condition the symptoms of which had been observed or had been treated before the insurance agreement was concluded and were not reported, or were reported incorrectly to the Insurance Company before the insurance agreement was concluded, if the Insurance Company expressly asked about them and they could have affected the decision to conclude the insurance agreement, or the decision on the terms of the concluded agreement.
6. The Insurance Company is not liable for insurance events which require:
  - a. genetic tests;
  - b. a positron emission tomography (PET);
  - c. mandatory vaccinations according to the schedule of vaccinations (current Message from the Chief Sanitary Inspector for a given year on the Program of Protective Vaccinations).

#### *When can I receive treatment? How to obtain the cash benefit?*

### § 6. Benefits

1. The Insured Party is entitled to the following benefits, **justified from the medical point of view**,

covered by the selected insurance option described in the Catalogue of Benefits:

- a. in the form of non-cash medical services, a medical benefit completed via the Helpline 24 h;
  - b. the payment of a benefit in the amount limited by GGO, namely the cash benefit;
2. If the Insured Party arranged the performance of a medical service via the Helpline 24 h and completed it in the Medical Institution indicated by the consultant, or declared the date and place of performance to the Helpline 24 h after the Insured Party arranged it on their own, the Insured Party does not bear any additional costs of this service, the benefit is completed without cash involved, unless the provisions of the Catalogue of Benefits state otherwise and the service is not covered by the selected insurance option.
  3. If the Insured Party resigns from the non-cash medical services, they may obtain a benefit in the amount limited by GGO. In this case, in order to confirm the occurrence of an insurance event, the Insured Party is obliged to send the following to the Insurance Company:
    - a. an original or a legible copy of the invoice/bill issued in connection with the performance of the medical service,
    - b. the filled in document "Request to pay the benefit" drawn up on the Insurance Company's form available at [www.tuzdrowie.pl](http://www.tuzdrowie.pl), or
    - c. send those documents on – line, after logging in the Insured Person's Portal.
  4. In order to obtain the cash benefit in the on–line mode in an entity with access to the system for granting on-line benefits, it is necessary for the Insured Party to sign and accept the document "Form for receiving the benefit" drawn up on the Insurance Company's form.
  5. In order to obtain the cash benefit in the on–line mode or a medical benefit in the Medical Institution indicated by the Helpline 24h, it is necessary for the Insured Party to present the Insured Party's ID with a photograph.
  6. If it is necessary to use the medical services described in the Catalogue of Benefits as services requiring the consent of a Medical Consultant as part of insurance protection, the Insured Party is obliged to send to the Insurance Company a referral for a given diagnostic test, treatment or another service to the following e-mail address in order to obtain this consent: [ubezpieczenia@tuzdrowie.pl](mailto:ubezpieczenia@tuzdrowie.pl) or as an MMS to the number 723 444 999.
  7. In the case described in passage 1a and passage 6, the Insurance Company may apply to the Insured Party within 1 business day with a request to send additional explanations or medical documents confirming the medically justified need and safety to conduct such services or a request to undergo a medical examination, performed by a specialist in a given medical field indicated by the Insurance Company . The costs of such examination are borne by the Insurance Company.
  8. In the case referred to in passage 7, the Insurance Company is obliged to issue the decision within 2 business days from obtaining the additional

documents or from performing the medical examination.

9. In the case described in passage 1b and passage 3, the Insurance Company may apply to the Insured Party to provide additional information or medical documentation necessary to determine the Insured Party's right to the benefit. The Insured Party will be informed about these requirements within 4 business days from receiving a message to the telephone number or/and e-mail address specified in the application.
10. In the case referred to in passage 9, the Insurance Company is obliged to issue the decision within 2 business days from obtaining the additional information or obtaining another necessary documentation.
11. The granted cash benefit in the amount limited by GGO will be sent to the bank account indicated by the Insured Party and specified in the document "Request to pay the benefit".
12. Detailed information regarding the procedures for obtaining insurance benefits is described in the Catalogue of Benefits for each scope of benefits.
13. The decision of the Insurance Company on the refusal or the reduction in the amount of the benefit along with the justification will be delivered to the Insured Party or transferred in writing with registered mail to the Insured Party's address or to the e-mail address specified in the application within 4 business days from the day of receiving the request to pay the benefit or issuing the decision described in passage 8 or 10.

### *When and how can I get insured?*

#### **§ 7. Concluding the insurance agreement**

1. The insurance agreement may be concluded for a person who is not older than 70.
2. In the case of children under 7 years of age, it is possible to conclude an insurance contract only if at least one of the parents or legal guardians is covered by insurance. The insurance agreement is concluded on the basis of the Insuring Party's request provided to the Insurance Company.
3. The request contains the following data:
  - a. full name or name and address of the Insuring Party, the PESEL number - if the Insuring Party is a natural person, the KRS number - if the Insuring Party is entered into the Polish National Court Register, NIP (Polish tax identification number);
  - b. full name, address of the Insured Parties, dates of birth, the PESEL number or the passport number, telephone number and e-mail address,
  - c. the insurance option;
  - d. the insurance period.
4. The Insurance Company may make concluding the insurance agreement conditional on obtaining additional information regarding the health condition and the lifestyle of the person whom is to be insured.

5. Concluding the insurance agreement is confirmed by the Insurance Company by transferring the policy to the Insuring Party in the manner agreed with the Insuring Party, making it possible to become familiar with its content and accept its provisions.
6. It is understood that the payment of premium or its first instalment confirms, per se, the acceptance of the insurance contract records.
7. Information on the selected insurance variant and option may be found in the insurance policy.

### *When can I begin using the services?*

#### **§ 8. Duration of insurance agreement**

1. The beginning of the insurance period is the date agreed between the parties in the insurance agreement and specified in the policy.
2. The insurance protection for specified benefits starts at the moment indicated in the insurance policy as the beginning of the insurance period, but not earlier than after the expiry of the grace periods for specified benefits and not earlier than on the next day after the contribution or its first instalment is paid.
3. The insurance agreement is concluded for a period of one year (12 months), subject to passage 4.
4. The duration of the agreement is automatically extended by another insurance year (12 months) if the agreement is not terminated in writing by the Insuring Party or if the Insurance Company does not propose new insurance terms for another insurance year at least 30 days before the expiry of its duration.

### *When does the insurance end?*

#### **§ 9. Termination and withdrawal from the insurance agreement**

1. The Insuring Party has the right to withdraw from the insurance agreement within 30 days and when the Insuring Party is an entrepreneur - within 7 days from concluding the agreement. The withdrawal from the insurance agreement does not release the Insuring Party from the obligation to pay the contribution for the period in which the Insurance Company provided insurance protection.
2. The Insuring Party may terminate the insurance agreement at any time throughout its duration with a one-month notice period starting on the last day of the month in which the Insurance Company received the statement on the termination. The termination of the insurance agreement does not release the Insuring Party from the obligation to pay the contribution for the notice period.
3. The failure to pay the premium or the next instalment of the contribution, despite a prior call to the Insuring Party to pay the contribution within no less than 7 days, entitles the Insurance Company to terminate the agreement, but it does not release the Insuring Party from the obligation

to pay the contribution for the period in which the Insurance Company provided insurance protection.

4. If the Insuring Party terminates the agreement, the insurance agreement may be concluded again after 6 months counted from the last day of the duration of insurance protection.
5. The Insurance Company may terminate the insurance agreement if there is a change in legal regulations resulting in the inability to execute the insurance agreement.

#### **§ 10. Insurance sum**

The insurance sum is indicated in the Catalogue of Benefits.

### *How is the insurance premium calculated?*

#### **§ 11. Premium**

1. The insurance contribution is calculated after risk assessment on the basis of the tariff valid as at concluding the insurance agreement, or on the day of extending the insurance protection for the next period.
2. The premium may be higher from the contribution indicated in the tariff due to factors increasing the medical risk of the Insured Party, such as the state of health, the lifestyle, the occupation.
3. The premium is paid in the frequency of instalments requested by the Insuring Party: monthly, quarterly, semi-annually or annually
4. The Insuring Party is obliged to pay the premium.
5. The premium or the first instalment of the premium should be paid at least 5 days before the selected starting date of insurance protection- to the bank account number of the Insurance Company indicated in the insurance offer.
6. The payment dates of subsequent premium instalments and their amount are specified in the policy.
7. The premium or the instalment of the premium should be paid to the bank account of the Insurance Company indicated in the policy.
8. If the premium is paid in the form of a bank transfer or postal order, the date of payment shall be the date of submission of the direct debit at the bank or post office to the appropriate bank account of Insurance Company.
9. When the premium is paid in instalments, when the instalment of the contribution is paid in an amount higher than the due instalment, the Insurance Company will credit the overpaid amount to the next instalment of the premium, unless the Insuring Party requests the refund of the overpayment.
10. If there is an overpayment of the premium at the end of the insurance period, the Insurance Company will return the overpaid amount to the bank account indicated by the Insuring Party within 30 days from the end of the insurance period.

## What are the right of Insured Party and Insurance Company ?

### § 12. Rights and obligations of the parties

1. The Insuring Party and the Insured Party are obliged to truthfully provide the Insurance Company with any known circumstances which were requested in the application, or about which they were asked in any other form. If the Insurance Company concluded the insurance agreement despite the lack of the Insuring Party's answers to particular questions; the omitted circumstances are deemed irrelevant.
2. The Insuring Party and the Insured Party are obliged to provide the Insurance Company with any information which is required to determine the right to receive the benefit.
3. The Insurance Company is released from the obligation to grant the benefit when the Insuring Party or the Insured Party violated the obligations stated in passages 1 – 2 and provided false circumstances or information.
4. The Insurance Company cannot refuse to grant the benefit if it concluded the insurance agreement despite the lack of an answer to a question asked in the application or in other documents, and the insurance event is related to questions to which answers were not given.
5. The Insuring Party or the Insured Party have the right to inspect the Insurance Company's documentation regarding the conclusion of the insurance agreement and the determination of the right to receive the benefit as well as to execute extracts or photocopies of this documentation at their own expense.
6. The Insurance Company is obliged to:
  - a. provide the Insuring Party with the OWU and the Catalogue of Benefits,
  - b. issue the policy and the Insurance Cards to the Insuring Party,
  - c. provide the Insuring Party or the Insured Party with information and documents regarding the insurance protection, including information and documents which affected the determination of liability and the scope of the benefit, within 7 days from the date of the application or the inquiry,
  - d. provide the Insuring Party, in writing in order to be valid, with differences between the provisions of the insurance agreement and OWU. The provision does not apply to agreements concluded by way of negotiations, confirmed with an insurance agreement and/or a policy signed by the Insurance Company and the Insuring Party.

### § 13. Obligations of the Insured arising from the provisions of the Personal Data Protection Act

- 1 The Policyholder is obliged to provide the Insurance Company with the Insured's consent to process personal data.
- 2 The consents are signed by the Insured on the form provided by the Insurance Company.
- 3 In addition, before obtaining the Insured's consent, the Insured is obliged to read it with the information of the Insurance Company regarding the processing of personal data arising from applicable law, provided to the Insured in a separate document.
- 4 The Policyholder is responsible for the failure to obtain the Insured's consent for the processing of personal data.
- 5 Until the Insured's consent to the processing of personal data by the Insured, the insurance cover includes the right to cash benefits, the acquisition of which is described in § 6 para. 3.
- 6 In order to secure the Insured's rights to protection of personal data, including health data, Medical Benefits and On-line Cash Benefits are due to the Insured from the 3rd business day after the Insurance Company receives the Insured's consent to process personal data for through the Policyholder or the Insured's consent by the Insurance Company in another way, in particular via the form at [www.tuzdrowie.pl](http://www.tuzdrowie.pl), during the first login on the Insured Portal or via e-mail to the address [ubezpieczenia@tuzdrowie.pl](mailto:ubezpieczenia@tuzdrowie.pl) or traditional mail to the address of the seat Insurance Company.

### § 14. Information regarding the processing of personal data

1. The Administrator of Insured's personal data provided by the Insured is Insurance Company.
2. The Insurance Company can be contacted via the email address: [biuro@tuzdrowie.pl](mailto:biuro@tuzdrowie.pl), contact form at [www.tuzdrowie.pl](http://www.tuzdrowie.pl), by phone at 58 888 2 999 or in writing to the address of the seat of the Insurance Company.
3. The Insurance Company has appointed a Data Protection Inspector who can be contacted via email [iod@tuzdrowie.pl](mailto:iod@tuzdrowie.pl), by phone at 58 888 2 999 or in writing to the address of the administrator's seat.
4. You can contact the Data Protection Officer in all matters regarding the processing of personal data and the exercise of rights related to data processing.
5. Insured's personal data are processed for the purpose:
  - a. conclusion and performance of a health insurance contract, including insurance risk assessment - the legal basis for processing is the necessity of data processing to conclude and perform the contract and consent to the processing of health data,
  - b. insurance risk assessment in an automated manner as part of customer profiling before the conclusion of the contract - the legal basis for processing is the legal

obligation incumbent on the administrator and consent to the processing of health data,

- c. direct marketing of the Insurance Company's own products and services, including for analytical and profiling purposes - the legal basis for data processing is the necessity of processing to realize the legitimate interest of the Insurance Company; the legitimate interest of Towarzystwo Ubezpieczeń is direct marketing of its services,
  - d. the Insurance Company fulfills its obligations related to counteracting money laundering and terrorist financing - the legal basis for data processing is the necessity to fulfill the legal obligation incumbent on the administrator arising from the provisions on counteracting money laundering and terrorist financing,
  - e. to fulfil obligations by TU ZDROWIE SA in relation to reporting FATCA/CRS - the legal basis for processing is the necessity to process data for compliance with legal obligation to fulfil international taxation obligations and to implement FATCA legislation, and to comply with the legal provision on automatic exchange of tax information with other countries to which TU ZDROWIE SA is subject to;
  - f. in the event of legal redress related to your health insurance contract - the legal basis for processing is the necessity to process data for the purposes of the legitimate interest pursued by TU ZDROWIE SA; the legitimate interest of TU ZDROWIE SA is ability to seek redress,
  - g. should the need to act against insurance crimes occur - the legal basis for processing is the necessity to process data for the purposes of the legitimate interest pursued by TU ZDROWIE SA; the legitimate interest of TU ZDROWIE SA is possibility to act against and investigate crimes committed against the Insurance Company,
  - h. risk reinsurance – the legal basis for processing is the necessity to process data for the purposes of the legitimate interest pursued by TU ZDROWIE SA; the legitimate interest of TU ZDROWIE SA is to decrease the insurance risk related with the contract signed by you or for you.
6. TU ZDROWIE S.A. will receive personal data such as:
    - a. name, surname, PESEL/ passport number, date of birth, gender, mobile phone number and the Insured Person's e-mail address to carry out the insurance contract;
    - b. information on performed medical services and circumstances of their performance from medical provider/s or medical facilities provided in order to account for the medical services and to create damage registers required by the Polish law.
  7. Personal data will be stored for the limitation period that applies to contractual claims regarding health insurance contracts, or until expiry of data storing obligation under legal provisions, in particular obligation to store accounting records regarding insurance contracts, obligation to store data under the legal provisions regarding prevention of money laundering and terrorist financing; legal provisions on fulfilling international taxation obligations, and in relation to implementation of FATCA legislation, and legal provisions on automatic exchange of tax information with other countries..
  8. TU ZDROWIE SA will cease to process your data to perform direct marketing activities, including profiling and analysing, if you object to processing your data for such purposes.
  9. Personal data may be made available to entities providing medical services, entities providing services connected with the insurance for the persons insured by TU ZDROWIE SA, entities providing medical helpline service and reinsurance undertakings.
  10. Moreover, your data may be made available to entities that process personal data based on TU ZDROWIE SA authorisation. These are inter alia IT service providers, entities processing data for the purpose of debt recovery, marketing agencies, or insurance agents – however such entities only process data based on an agreement with TU ZDROWIE SA and solely in accordance with TU ZDROWIE SA instructions.
  11. Personal data, excluding information on performed medical services, are made available to the Insurers in order to provide proper insurance coverage/ calculate premium payable.
  12. Personal data shall not be transferred to subjects based in third countries outside European Economic Area.
  13. The Insured has the right to access your data and the right to amend it, erase it or restrict its processing under the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (Official Journal of the European Union L number 119, page 1, hereinafter referred to as GDPR).
  14. If the basis of your personal data processing is a legitimate interest of TU ZDROWIE SA, you have the right to object to processing your personal data.
  15. In particular, you have the right to object to processing your personal data for direct marketing purposes and profiling.
  16. If the basis for the processing of personal data is the Insured's consent, the Insured has the right to withdraw it. Withdrawal of consent does not affect the lawfulness of data processing on the basis of consent before its withdrawal.
  17. If the basis for the processing of personal data is the conclusion and performance of the insurance contract or on the basis of the Insured's consent - The Insured has the right to transfer data, i.e. To receive data from TU ZDROWIE SA in an ordered, commonly used and machine-readable format and transfer data to another administrator.
  18. The insured also has the right to lodge a complaint with the supervisory body dealing with the protection of personal data.
  19. In order to exercise your rights you should contact TU ZDROWIE SA or the Inspector of Data Protection. Contact details are available at [www.tuzdrowie.pl](http://www.tuzdrowie.pl) .
  20. In the processing of your data, no automated decisions will be made.
  21. Providing your personal data as well as giving the consent to process data concerning your health in relation to signing up the insurance contract, is necessary to carry out the insurance contract.
  22. Providing your personal data for the marketing purposes is voluntary.

### § 15. Information on the nature of the remuneration received by persons performing distribution activities

1. The employees of the Insurance Company performing distribution activities receive regular monthly salary and bonuses from concluded insurance contracts.
2. Agents for the conclusion or conclusion of an insurance contract shall receive from the Insurance Company a remuneration representing an agreed percentage of the monthly premium.
3. Insurance brokers for the conclusion of the insurance contract receive remuneration from the Insurance Company constituting the agreed percentage of the monthly premium or are paid by the Policyholder.

### § 16. Complaints and appeals

#### 1. Submitting complaints

- 1) Each Customer willing to submit objections regarding services provided by the Insurance Company may submit a Complaint.
- 2) The Complaint may be submitted in each unit of the Insurance Company.
- 3) The Complaint may be submitted:
  - a. in writing - in person, in a unit of the Insurance Company for Customers, or via mail as defined by Art. 3(21) of the Polish Act dated November 23, 2012 - Postal Law (Journal of Laws, item 1529) to the following address: Towarzystwo Ubezpieczeń ZDROWIE S.A., ulica Śląska 17, 81-319 Gdynia, the additional marking on the envelope: "Reklamacja" – will improve the procedure of examining the Complaint;
  - b. orally - by phone or in person during the customer's visit in the unit of the Insurance Company;
  - c. in electronic form using means of electronic communication, to the e-mail address: reklamacje@tuzdrowie.pl.
- 4) The complaint should contain:
  - a. marking "Reklamacja",
  - b. the Customer's full name,
  - c. the Customer's contact address,
  - d. the Customer's e-mail address,
  - e. the Customer's PESEL number,
  - f. the date and number of the insurance agreement concluded with the Insurance Company,
  - g. the date and number of the insurance policy confirming the conclusion of the agreement with the Insurance Company,
  - h. indication of the insurance option used by the Customer and to which the Complaint applies,
  - i. the description of irregularities in the activities of the Insurance Company to which the Complaint applies,

- j. the indication of what the Customer submitting the Complaint proposes,
- k. the indication whether the Customer requests the delivery of the answer to the Complaint via e-mail,
- l. the Customer's signature.

- 5) Complaints without the data referred to in point 4 above will be examined by the Insurance Company to the extent to which it is possible. If the customer does not indicate contact data, this may prevent the delivery of the answer to the Complaint.

#### 2. Mode of examining Complaints

- 1) After the Customer submits a Complaint, the Insurance Company examines the Complaint and provides the Customer with an answer in paper form or with the use of another Durable Medium.
- 2) The Insurance Company may deliver the answer to the Complaint via e-mail only at the request of the Customer.
- 3) The Complaint should be answered without any unnecessary delays, but not later than within 30 days from receiving the Complaint. The deadline for answering the Complaint will be deemed to have been observed if the answer is sent before its expiry.
- 4) In particularly complex cases, preventing the examination of the Complaint and answering it within the deadline referred to in point 3 above, the Insurance Company provides the Customer who submitted the Complaint with the following information:
  - a. the explanation of the cause for the delay;
  - b. the indication of circumstances which need to be taken into account in order for the matter to be examined;
  - c. determines the expected date of examining the Complaint and granting the answer that cannot exceed 60 days from receiving the Complaint.
- 5) When examining the Complaint, the Insurance Company may collect necessary documents and take other evidence according to valid legal regulations.
- 6) If the deadline specified in point 3 above and, in certain cases the deadline specified in point 4 above, is not met, the Complaint is considered examined according to the Customer's wish.
- 7) The answer to the Complaint should contain, in particular:
  - a. the actual and legal justification, unless the Complaint was examined according to the Customer's wish;
  - b. comprehensive information about the position of the Insurance Company regarding the submitted objections, including the indication of relevant fragments of the agreement template or the agreement;
  - c. the full name of the answering person indicating their official position;

- d. the deadline in which the claim raised in the Complaint examined according to the Customer's wish will be completed, not longer than 30 days from drawing up the answer.
- 8) If the claims resulting from the Customer's Complaint are not taken into account, the content of the answer to the Complaint should also contain information about the possibility to:
- appeal from the position contained in the answer, as well as the method for submitting this Appeal;
  - submit a request to the Financial Spokesperson to examine the matter;
  - file a suit to a common court indicating the entity that should be sued and the court locally competent to examine the matter.
- 3. Appeal mode**
- The Customer may appeal from the answer to the Complaint.
  - The Appeal may be submitted to the Insurance Company's Management within 14 days from the day when the Customer receives the answer to the Complaint. The deadline for sending this Appeal will be deemed to have been observed if the Appeal is sent before its expiry.
  - The Complaint may be submitted:
    - in writing – via mail as defined by Art. 3(21) of the Polish Act dated November 23, 2012 – Postal Law (Journal of Laws, item 1529) to the following address: Towarzystwo Ubezpieczeń ZDROWIE S.A. - ulica Śląska 17, 81-319 Gdynia, the additional marking on the envelope: ODWOŁANIE - will improve the procedure for examining the Appeal;
    - in electronic form using means of electronic communication, to the e-mail address: reklamacje@tuzdrowie.pl.
  - The Appeal should indicate the answer to the Complaint being appealed against and the reasons for which the Customer questions the answer to the Complaint.
  - After submitting the Appeal, the Insurance Company examines the Appeal and provides the party submitting the Appeal with an answer in the form of a decision in writing or via e-mail.
  - The answer to the Appeal should be granted without any unnecessary delays, but not later than within 30 days from receiving the Appeal. The deadline for answering the Complaint will be deemed to have been observed if the answer is sent before its expiry.
  - If it is impossible to examine the Appeal within the deadline indicated above, the Insurance Company sends to the Customer information before the expiry of this deadline that examining the Appeal within the thirty-day deadline is not possible indicating the reasons for the delay and the expected date of examining the appeal.
  - If the Appeal was submitted after the deadline indicated in point 2 above, the Insurance Company's Management may, but does not need to, examine the Appeal.
- 9) When examining the Appeal, the Insurance Company may collect necessary documents and take other evidence according to valid legal regulations
- 10) As a result of examining the Appeal, the Insurance Company issued a decision taking into account the Appeal or refusing to examine the Appeal. When the Appeal is taken into account, the Insurance Company changes the answer to the Complaint in relation to which the Appeal was submitted.
- 4. Complaint not taken into account – possible further actions**
- When the Complaint is not taken into account, regardless of the possibility to submit the appeal,
    - the party submitting the Complaint may request the matter to be examined by the Financial Spokesperson;
- 5. The party submitting the Complaint may file a suit to a common court.** In this case, the entity that should be sued is Towarzystwo Ubezpieczeń ZDROWIE Spółka Akcyjna, entered into the Register of Entrepreneurs of the Polish National Court Register kept by the District Court Gdańsk-Północ in Gdańsk, 8th Commercial Department of the Polish National Court Register under number: 0000362027, with the Polish tax identification number (NIP): 5862257567, with the Polish number in the register of business units (REGON): 221064894. The court locally competent to examine the matter will be the District Court in Gdynia (Plac Konstytucji 5, 81-354 Gdynia) – when the value of the object of the dispute does not exceed PLN 75,000 or the Regional Court in Gdańsk (address: Nowe Ogrody 30/34, 80-803 Gdańsk) – when the value of the object of the dispute exceeds PLN 75,000. Instead of the courts indicated above, the suit may be filed in a district court (if the value of the object of the dispute does not exceed PLN 75,000) or a regional court (if the value of the dispute subject exceeds PLN 75,000) competent for the place of residence or the registered office of the insuring party, the insured party, the beneficiary or the party authorized from the insurance agreement, the heir of the insured party or the heir authorized from the insurance agreement
- 6. Grievance**
- In cases other than those indicated in § 13(1)(1), the Customer and the Insuring Party may submit a Grievance being an intervention regarding irregularities in the activities of the Insurance Company or entities cooperating with the Insurance Company not related to concluding or executing a specific insurance agreement.
  - The Grievance may be submitted to the Insurance Company:
    - in writing – via mail as defined by Art. 3(21) of the Polish Act dated November 23, 2012 – Postal Law (Journal of Laws, item 1529) to the following address: Towarzystwo Ubezpieczeń ZDROWIE S.A., ulica Śląska 17, 81-319 Gdynia, the additional marking on the envelope: SKARGA – will improve the procedure for examining the Grievance;
    - orally- by phone;

- c. in electronic form using means of electronic communication, to the e-mail address: reklamacje@tuzdrowie.pl.
- 3) After submitting the Grievance, the Insurance Company examines the Grievance and provides the party submitting the Grievance with an answer in writing or via e-mail.
- 4) The answer to the Grievance should be granted without any unnecessary delays, but not later than within 30 days from receiving the Grievance. The deadline for answering the Complaint will be deemed to have been observed if the answer is sent before its expiry.
- 5) In particularly complex cases, preventing the examination of the Grievance and answering it within the deadline referred to in point 5.5, the Insurance Company may prolong the term for examining the Grievance to 60 days.
- 6) When examining the Grievance, the Insurance Company may collect necessary documents and take other evidence according to valid legal regulations.
- 7) An appeal is not granted from the answer to the Grievance.

#### § 17. Final provisions

1. All notices and statements addressed to the Insurance Company should be submitted in writing with receipt or sent by registered mail to the address of the registered office or to the e-mail address of the Insurance Company: [biuro@tuzdrowie.pl](mailto:biuro@tuzdrowie.pl).
2. If the Insuring Party or the Insured Party changed their contact address or their e-mail address, they should immediately notify the Insurance Company about this fact, providing the current contact or e-mail address

These OWU, code OWU/02/2019, were adopted by virtue of a resolution of the Management UZ/25/2019 on November 20, 2019 and apply to insurance agreements binding after that day.

CEO  
Aleksander Roda



ViceCEO  
Sławomir Koszewski





## **Towarzystwo Ubezpieczeń ZDROWIE Spółka Akcyjna**

Kapitał zakładowy w wysokości 21 950 000 zł. opłacony w całości,  
Sąd Rejonowy Gdańsk-Północ w Gdańsku, VIII Wydział Gospodarczy  
KRS 0000362027, NIP 5862257567, REGON 221064894

**Siedziba:** ul. Śląska 17, 81-319 Gdynia, tel. 58 888 2 999  
**Biura Handlowe:** ul. Kłobucka 23, 02-699 Warszawa, tel. 58 888 2 999  
ul. Bocheńskiego 38A lok. 225, 40-859 Katowice, tel. 58 888 2 999