Евразия
СТРАХОВАЯ КОМПАНИЯ

APPROVED by
Resolution of the Board of Directors of
Eurasia Insurance Company JSC
Minutes dated October 21, 2026

RULES
FOR VOLUNTARY INSURANCE OF PERSONS TRAVELLING ABROAD

Almaty, 2026

TABLE OF CONTENTS

Article 1. GENERAL PROVISIONS AND DEFINITIONS 3
Article 2. SUBJECT MATTER OF INSURANCE 5
Article 3. INSURED EVENTS AND INSURED RISKS 5
Article 4. ADDITIONAL OPTIONS 5
Article 5. EXCLUSIONS FROM INSURED EVENTS AND RISKS 6
Article 6. PROCEDURE FOR DETERMINING THE SUM INSURED 17
Article 7. INSURANCE PREMIUM 18
Article 8. DEDUCTIBLE 18
Article 9. INSURANCE CONTRACT EXECUTION PROCEDURE 19
Article 10. TERM AND TERRITORIAL SCOPE OF THE INSURANCE CONTRACT 20
Article 11. RIGHTS AND OBLIGATIONS OF THE PARTIES 20
Article 12. ACTIONS TO BE TAKEN BY THE POLICYHOLDER (INSURED PERSON) IN THE EVENT OF AN INSURED EVENT 24
Article 13. LIST OF DOCUMENTS CONFIRMING THE OCCURRENCE OF AN INSURED EVENT AND THE AMOUNT OF LOSS 25
Article 14. PROCEDURE, CONDITIONS AND TIME LIMIT FOR MAKING A DECISION ON THE PAYMENT OF INSURANCE INDEMNITY 26
Article 15. TRANSFER TO THE INSURER OF THE POLICYHOLDER'S RIGHTS TO RECOVER LOSSES (SUBROGATION) 28
Article 16. INSURANCE CONTRACT TERMINATION TERMS 28
Article 17. CONSEQUENCES OF AN INCREASE IN INSURANCE RISK DURING THE TERM OF THE INSURANCE CONTRACT 30
Article 18. ADDITIONAL PROVISIONS 30

Article 1. GENERAL PROVISIONS AND DEFINITIONS

1.1. These Rules for Voluntary Insurance of Persons Travelling Abroad (hereinafter referred to as the "**Rules**") of Eurasia Insurance Company JSC (hereinafter referred to as the "**Insurer**") have been prepared in accordance with the applicable laws of the Republic of Kazakhstan and set out the procedures and terms for entering into and performing voluntary insurance contracts for persons travelling abroad.

1.2. The provisions of these Rules shall apply to voluntary insurance contracts for persons travelling abroad concluded by the Insurer, unless otherwise expressly provided for in the relevant insurance contract.

1.3. Under these Rules, the Insurer concludes voluntary insurance contracts for persons travelling abroad with legal entities, regardless of their legal form or form of ownership, as well as with individuals, regardless of their citizenship.

1.4. For the purposes of these Rules, the following terms shall be used:

1) **Active Leisure** – physical activity or other activities undertaken by the Insured Person during the term of the insurance contract that involve increased physical exertion and/or an increased risk of injury, but do not constitute participation in sports as defined in these Rules.

2) **Sudden Acute Illness** – an unforeseen, rapidly developing deterioration in the health of the Policyholder/Insured Person occurring during the term of the insurance contract, posing a threat to their life and/or requiring urgent medical intervention, as well as a sudden exacerbation of a pre-existing chronic disease. Expenses arising from an exacerbation of a chronic disease shall be covered only for emergency or urgent medical assistance needed until the life-threatening symptoms or acute condition have been relieved.

3) **Medical Transportation** – transportation of the Insured Person, on emergency medical grounds, to the nearest medical facility by ambulance or ordinary means of transport, with or without the accompaniment of a medical professional, for the provision of emergency or urgent medical assistance.

4) **Ambulance Vehicle** – a specialized ground vehicle intended for the transportation of ill or injured persons and accompanying medical personnel.

5) **Accident** – a sudden event occurring against the will of the Insured Person during the term of the insurance contract and outside the territory of the Republic of Kazakhstan, resulting in injury, a sudden deterioration in the health of the Policyholder/Insured Person, or poisoning, which leads to illness or death.

6) **AML/CFT and FPWMD** – anti-money laundering, counter-terrorist financing and counter-proliferation financing (financing the proliferation of weapons of mass destruction).

7) **Repatriation** – arranging for the repatriation of the remains of a deceased Insured Person to the international airport in the Republic of Kazakhstan nearest to their permanent place of residence, or to the international airport in the country of permanent residence of the Policyholder/Insured Person.

8) **Immediate Family** – the parents, children, adoptive parents, adopted children, full and half-siblings, grandfather, grandmother and grandchildren of the Insured Person.

9) **Service Company (Medical Assistance Company/Assistance)** – a legal entity that has entered into an agreement with the Insurer to provide medical assistance to the Insured Person through technical, medical and other support following the occurrence of an insured event in accordance with these Insurance Rules.

10) **Accompanying Person** – a close relative, family member or other person accompanying the Policyholder/Insured Person where such accompaniment is medically necessary.

11) **Sport** – a sphere of socio-cultural activity comprising various sports disciplines that have developed in the form of sporting competitions and specialized training for participation in such competitions.

12) **Urgent Arrival of an Accompanying Person** – the arrival of an accompanying person

required in an emergency and in accordance with the attending physician's recommendation that an accompanying person travel to the medical facility where the Policyholder/Insured Person has been hospitalized in the country of temporary stay (if the Policyholder/Insured Person was travelling alone).

13) **Emergency Medical Assistance** – medical assistance provided in the event of sudden acute illnesses and conditions, or exacerbations of chronic diseases, requiring immediate medical intervention to prevent significant harm to health and/or eliminate a threat to life.

14) **Emergency Medical Evacuation** – transportation of the Policyholder/Insured Person, provided that they are medically fit for transportation, accompanied by medical personnel and/or an Accompanying Person, from the country of temporary stay (the territory of insurance) to the international airport or medical facility nearest to the Insured Person's permanent place of residence.

Emergency Medical Evacuation shall be carried out on the basis of the attending physician's medical opinion, confirmed by the opinion of the Assistance Provider's physician, provided that there are no medical contraindications, in the following cases:

a) the necessary medical assistance cannot be provided to the Insured Person in the country of temporary stay (the territory of insurance);

b) the cost of further inpatient treatment exceeds the sum insured (liability limit) stipulated in the insurance contract, and the Policyholder (Insured Person) refuses to pay the difference out of their own funds.

The costs of Emergency Medical Evacuation shall be covered within the sum insured specified in the insurance contract.

In the event of Emergency Medical Evacuation of the Policyholder/Insured Person, such costs shall include the arrangement and payment for the evacuation of the Policyholder's/Insured Person's minor children (under 18 years of age) travelling with them and left unattended, to an international airport or their permanent place of residence in the country of citizenship and/or permanent residence of the Policyholder/Insured Person, accompanied by an Accompanying Person appointed by the Insurer (Assistance).

15) **Policyholder** – a legal entity of any legal form, an individual entrepreneur, or a legally competent individual who has entered into an insurance contract with the Insurer.

16) **Insured Person** – an individual aged up to and including 101 years, in respect of whom insurance coverage is provided. The insurance contract may cover one or more Insured Persons, and the details of each Insured Person shall be specified in the insurance contract. Unless otherwise provided for in the insurance contract, the Policyholder shall be the Insured Person.

17) **Beneficiary** – a person entitled to receive an insurance payment under the insurance contract:

1) Service Company (Medical Assistance) – where the Service Company provides services to the Insured Person, in an amount equal to the cost of the services rendered;

2) Insured Person – in the cases provided for in these Rules. The Insured Person may also be the Policyholder. Where the Insured Person is a minor, the Beneficiary shall be their parent, legal guardian or custodian. In the event of the death of the Insured Person, the Beneficiary shall be their lawful heirs.

18) **Deductible** – an amount specified in the insurance terms and conditions, up to which the Insurer is released from the obligation to indemnify the loss.

19) **Internet Resource** – the Insurer's official website on the Internet information and communications network.

20) **Insurance Contract** – an agreement between the Policyholder and the Insurer under which the Insurer undertakes, in consideration of the insurance premium stipulated in the insurance contract, to make an insurance payment to the Beneficiary upon the occurrence of an insured event, within the sum insured specified in the insurance contract.

Article 2. SUBJECT MATTER OF INSURANCE

2.1. The subject matter of insurance is the Policyholder's/Insured Person's property interests, not contrary to the legislation of the Republic of Kazakhstan, relating to the incurrence of additional, unforeseen expenses for medical, transportation and other services arising as a result of an insured event.

Article 3. INSURED EVENTS. INSURED RISKS.

3.1. An insured event is the occurrence, during the term of the Insurance Contract and within the territory of insurance, of unforeseen expenses incurred by the Insured Person as a result of a sudden acute illness or an accident, upon the occurrence of which the Insurer becomes liable to make an insurance payment.

3.2. An insured risk is an anticipated event characterized by probability and fortuity, against the occurrence of which insurance is provided, namely:

- Sudden acute illness of the Policyholder/Insured Person;
- An accident involving the Policyholder/Insured Person;
- A sudden exacerbation of a chronic disease of the Policyholder/Insured Person that poses a threat to their life or requires emergency medical assistance;
- Death of the Policyholder/Insured Person resulting from a sudden acute illness or an accident.

3.3. Within the scope of the insured event specified in Clause 3.1 of this Article, the following expenses shall be covered, where they relate to the arrangement and/or provision of:

1) emergency medical assistance;
2) emergency dental care, including pain-relief treatment for a tooth, within the limit specified in the Insurance Contract;
3) medical transportation;
4) emergency medical evacuation;
5) repatriation of the Insured Person's remains in the event of their death;
6) evacuation of children;
7) urgent arrival of an Accompanying Person;
8) emergency medical assistance for acute and urgent medical conditions arising from the exacerbation of chronic diseases and not falling within the exclusions from insured events provided for in these Rules and the Insurance Contract.

3.4. Where the Insurance Contract includes the "Active Leisure" option, the events specified in Clause 3.2 of this Article that occur while the Insured Person is engaged in active leisure shall also be recognized as insured events, provided that the requirements of these Rules and the Insurance Contract are complied with.

ARTICLE 4. ADDITIONAL OPTIONS

4.1. By mutual agreement of the Parties, the Insurance Contract may additionally include one or more of the following optional coverages:

4.1.1. "Active Leisure" Option – an additional term of the Insurance Contract under which insurance coverage extends to events occurring while the Insured Person is engaged in active leisure, within the sum insured (applicable limits) and subject to the exclusions provided for in these Rules and the Insurance Contract.

4.1.2. "Already Travelling" Option – an additional term of the Insurance Contract allowing the Insurance Contract to be concluded in respect of a Policyholder/Insured Person who is already outside the territory of the Republic of Kazakhstan on the date of conclusion of the Insurance Contract. The insurance coverage shall commence upon expiry of three (3) calendar days from the date of conclusion of the Insurance Contract (the waiting period), but not earlier than the

commencement date of insurance coverage specified in the Insurance Contract.

Article 5. EXCLUSIONS FROM INSURED EVENTS AND RISKS

5.1. General Provisions

5.1.1. An event shall not be recognized as an insured event if it falls within the exclusions from insurance coverage set out in Section 5.2 of this Article.

5.1.2. If an event is recognized as an insured event, the Insurer shall pay only those expenses covered by the Insurance Contract. The expenses specified in Section 5.3 of this Article shall not be reimbursed.

5.1.3. If an event meets the criteria of an insured event but grounds for refusal exist under the legislation of the Republic of Kazakhstan, these Rules or the Insurance Contract, the Insurer shall be entitled to refuse payment of insurance benefits, in whole or in part, in accordance with the procedure set out in Section 5.4 of this Article.

5.1.4. Restrictions relating to anti-money laundering, counter-terrorist financing and counter-proliferation financing, as well as the application of targeted financial sanctions, shall apply in accordance with Section 5.5 of this Article.

5.1.5. The existence of an exclusion, a non-covered expense or grounds for refusal to make an insurance payment shall be determined separately for each reported event and each type of expense.

5.1.6. The Insurer shall not be entitled to refuse to make an insurance payment solely on the grounds of a formal breach of these Rules or the Insurance Contract by the Policyholder, Insured Person or Beneficiary, if such breach:

1) is not causally related to the occurrence of the insured event or the increase in the amount of expenses;

2) did not prevent the Insurer from establishing the occurrence, causes and circumstances of the insured event;

3) did not prevent the Insurer from determining the amount of expenses subject to reimbursement.

5.1.7. If a breach or exclusion applies only to part of the expenses claimed, the Insurer shall be entitled to refuse reimbursement only in respect of that part. The remaining substantiated expenses shall be reimbursed in accordance with the terms and conditions of the Insurance Contract.

5.2. Exclusions from Insurance Coverage

5.2.1. Unless otherwise expressly provided for in the Insurance Contract, illnesses, injuries, death and other events directly resulting from the following shall not be recognized as insured events:

1) the effects of a nuclear explosion, ionizing radiation, radiation or radioactive contamination;

2) acts of war, whether or not war has been declared, civil war, armed conflict, invasion or the actions of foreign armed forces;

3) civil unrest, mass riots, uprisings, rebellions, revolutions or strikes;

4) a terrorist act, unless otherwise expressly provided for in the Insurance Contract.

Willful Misconduct and Unlawful Acts:

5.2.2. An event shall not be recognized as an insured event if it directly results from:

1) willful acts of the Policyholder, Insured Person or Beneficiary intended to cause harm to the life or health of the Insured Person or to cause an event that would otherwise qualify as an insured event;

2) acts of the Policyholder, Insured Person or Beneficiary recognized as an intentional criminal or administrative offence in accordance with the procedure established by the legislation of the Republic of Kazakhstan, where such acts are directly causally related to the event that occurred;

3) the Insured Person's participation in a fight, except in cases of self-defense, necessity, or an attack on the Insured Person, as confirmed by documents issued by competent authorities or other sufficient evidence;

4) attempted suicide or intentional self-harm by the Insured Person, except where such acts were committed in a state in which the Insured Person was unable to understand the nature and significance of their actions or to control them, as confirmed by medical records.

Alcohol, Narcotic Drugs and Other Substances:

5.2.3. An event shall not be recognized as an insured event if it occurs directly as a result of:

1) the Insured Person being under the influence of alcohol, narcotic drugs or toxic substances;

2) the Insured Person's use of narcotic drugs, psychotropic substances, their analogues or other intoxicating substances without medical indication;

3) the use of medicinal products without a doctor's prescription, in excess of the prescribed dosage or in breach of the instructions for their use established by the attending physician;

4) the Insured Person driving a vehicle without a valid driving license or other legal authorization to drive as required by the applicable laws of the country in which they are located (the territory of insurance), or while under the influence of alcohol, narcotic drugs or toxic substances;

5) the Insured Person knowingly allowing a person who does not have the legal right to drive or who is under the influence of alcohol, narcotic drugs or toxic substances to drive a vehicle.

Pre-existing Diseases and Medical Conditions:

5.2.4. Unless otherwise expressly provided for in the Insurance Contract, the following shall not be recognized to be insured events:

1) routine diagnostic examinations and planned treatment of chronic diseases;

2) treatment of any disease, injury or other medical condition that existed before the commencement of insurance coverage, where the relevant disease, injury or condition was the purpose of the trip or the Insured Person undertook the trip to obtain medical assistance;

3) continuation of a course of treatment, medical examination or rehabilitation commenced before the commencement of insurance coverage;

4) consequences and complications of diseases, injuries, surgical procedures or therapeutic treatment that occurred before the commencement of insurance coverage, where the need for medical assistance during the trip was expected or could reasonably have been foreseen in light of the available medical recommendations;

5) any disease or medical condition for which medical contraindications to travel existed before the commencement of insurance coverage and which the Insured Person knew or should have known about;

6) a trip undertaken contrary to the Insured Person's attending physician's written prohibition or recommendation not to travel;

7) a trip for which diagnosis, treatment, surgery, rehabilitation, childbirth or the receipt of other medical services was the primary or one of the primary purposes.

5.2.5. The provisions of Clause 5.2.4 of this Article shall not apply to emergency medical assistance required in the event of a sudden exacerbation of a chronic disease, provided that such coverage is stipulated in the Insurance Contract.

5.2.6. In the event of a sudden exacerbation of a chronic disease, only expenses for emergency medical assistance necessary to:

1) eliminate an immediate threat to the life of the Insured Person;

2) manage the acute condition;

3) stabilise the condition of the Insured Person;

4) enable medical evacuation or further self-directed treatment at the Insured Person's place of permanent residence,

shall be reimbursed.

Once the immediate threat to life has been eliminated and the Insured Person's condition has stabilized, expenses for further planned treatment, diagnostic examinations, monitoring and rehabilitation related to the chronic disease shall not be reimbursed.

Oncological Diseases, Mental Disorders and Certain Other Diseases:

5.2.7. Unless otherwise expressly provided for in the Insurance Contract, expenses related to the following shall not be recognized as insured events:

1) routine diagnosis and treatment of malignant and benign neoplasms, including their complications and consequences;

2) diagnosis and treatment of mental and behavioural disorders, depressive conditions, anxiety disorders, eating disorders and other conditions classified as mental and behavioural disorders;

3) treatment of conditions directly caused by the use of alcohol, narcotic drugs, psychotropic substances, toxic substances or other intoxicating substances;

4) diagnosis and treatment of sexually transmitted infections, including human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS);

5) diagnosis and treatment of diseases and conditions directly related to artificial insemination, infertility treatment, pregnancy planning or contraception.

5.2.8. If a disease referred to in Clause 5.2.7 of this Article first manifests itself during the period of insurance coverage as an acute condition posing an immediate threat to life, the Insurer shall pay for emergency medical assistance required solely to eliminate the threat to life and stabilize the condition of the Insured Person, unless otherwise expressly provided for in the Insurance Contract.

The existence of an established diagnosis, a disability status or registration with a medical facility for regular monitoring shall not constitute grounds for refusing to pay for medical assistance unrelated to the relevant disease or medical condition

Pregnancy and Reproductive Health:

5.2.9. Unless otherwise expressly provided for in the Insurance Contract, the following shall not be recognized as insured events:

1) routine pregnancy monitoring;
2) routine examinations, tests and consultations related to pregnancy;
3) childbirth, including premature childbirth;
4) medical assistance during the postpartum period;
5) medical assistance for newborns;
6) elective or voluntary termination of pregnancy;
7) diagnosis and treatment of infertility;
8) artificial insemination and other assisted reproductive technologies;
9) family planning and contraception measures.

5.2.10. Emergency medical assistance required due to a sudden complication of pregnancy posing an immediate threat to the life of the Insured Person shall be covered until the threat to life has been eliminated and the Insured Person's condition has stabilized, subject to the gestational period and coverage limit, where such period and limit are specified in the Insurance Contract.

If the relevant gestational period or a separate coverage limit is not specified in the Insurance Contract, expenses related to pregnancy shall not be covered by insurance, except for emergency medical assistance required as a direct result of an accident recognized as an insured event.

Infectious Diseases, Vaccination and Quarantine:

5.2.11. The mere fact that an epidemic or pandemic has been declared, or that a disease has been classified as a new, previously unknown or insufficiently studied type or strain, shall not

constitute grounds for refusing to recognize an event as an insured event, unless the relevant disease is expressly excluded under the Insurance Contract.

5.2.12. Diseases directly resulting from the Insured Person's willful or grossly negligent breach of the following shall not be recognized as insured events:

1) mandatory vaccination requirements established by the competent authorities of the country of entry or stay;

2) mandatory isolation or quarantine requirements;

3) officially established sanitary and epidemiological restrictions, provided that the relevant breach is confirmed by a competent authority and is directly causally related to the disease.

The absence of a non-mandatory or recommended vaccination shall not, in itself, constitute grounds for refusing to recognize an event as an insured event.

Sports, Active Leisure and High-Risk Activities:

5.2.13. Unless the Insurance Contract provides for the relevant additional coverage, illnesses, injuries or death directly resulting from the following shall not be recognized as insured events:

1) participation in professional sports;

2) participation in amateur sports expressly classified in the Insurance Contract as activities requiring additional insurance coverage;

3) participation in official or unofficial sporting competitions;

4) participation in training sessions, training camps, qualifying runs, trial starts or other preparation for sporting competitions;

5) participation in professional and/or amateur sports involving the use of mechanical, motorized, air or water vehicles;

6) participation in any active leisure activity, unless the Insurance Contract includes the "Active Leisure" option;

7) participation in any active leisure activity or sport not included in the list specified in the Insurance Contract;

8) participation in any sport or active leisure activity in violation of mandatory safety rules, without the required protective equipment, permit, license, certificate, instructor supervision or authorization, where such requirements are established by applicable law or the rules governing the relevant activity;

9) disregard of prohibitory or warning signs and established safety restrictions, including prohibitions on swimming, entering, driving, riding or remaining in hazardous areas, where such violation is causally related to an event exhibiting the characteristics of an insured event.

5.2.14. Specifying "Sports" as the purpose of travel in the Insurance Contract shall not, in itself, mean that all types of sports are covered. Insurance coverage shall apply only to the sports expressly specified in the Insurance Contract, subject to the applicable limits and exclusions established for such sports.

5.2.15. The inclusion of the "Active Leisure" option shall not extend insurance coverage to professional sports, sporting competitions or sports requiring separate insurance coverage, unless otherwise expressly provided for in the Insurance Contract.

Work and Professional Activities:

5.2.16. Unless the Insurance Contract expressly provides otherwise, illnesses, injuries or death directly resulting from the Insured Person's engagement in any of the following activities shall not be treated as insured events:

1) physical labour involving an increased risk of harm to life or health;

2) construction, installation, work at height, underground work, drilling, mining, loading and unloading, logging or blasting operations;

3) work involving industrial equipment, machinery, sources of increased danger, toxic, chemical, radioactive or explosive substances;

4) service as a crew member of an aircraft, watercraft or other means of transport;

5) service in military, paramilitary, law enforcement or rescue units;

6) service, training, training camps or exercises in the armed forces, military formations or law enforcement agencies;

7) other high-risk professional activities expressly specified in the Insurance Contract.

Territory and Period of Insurance:

5.2.17. The following occurrences shall not be treated as insured events:

1) events, including their consequences, occurring before the commencement or after the expiry of the insurance coverage period;

2) events occurring outside the territory of insurance specified in the Insurance Contract;

3) events occurring within the territory of the Republic of Kazakhstan, unless otherwise expressly provided for in the Insurance Contract;

4) events occurring in the country of permanent residence of the Insured Person, unless otherwise expressly provided for in the Insurance Contract;

5) where the "Already Travelling" option is selected, illnesses, injuries, symptoms and other events that arise or commence during the waiting period specified in the Insurance Contract, regardless of the date on which medical assistance is sought.

Other Exclusions:

5.2.18. Unless otherwise expressly provided for in the Insurance Contract, the following shall not be recognised as insured events:

1) civil liability of the Insured Person for causing harm to the life, health or property of third parties;

2) civil liability of the owner or driver of a vehicle;

3) illnesses, injuries or death resulting from self-medication, including the independent use of prescription medicines without a doctor's prescription;

4) illnesses or complications resulting from treatment provided by a relative of the Insured Person, except where emergency assistance was provided and obtaining assistance from another person was objectively impossible;

5) complications arising from medical services independently selected and received without the approval of the Insurer (Assistance Provider), where prior approval was objectively possible;

6) consequences of the Insured Person's voluntary refusal to comply with the medical prescriptions and recommendations of the attending physician, where such refusal is directly causally related to a deterioration in the Insured Person's condition or an increase in expenses.

5.3. Non-Covered Expenses

5.3.1. Regardless of whether an event is recognised as an insured event, unless otherwise expressly provided for in the Insurance Contract, expenses for services, goods and procedures that do not constitute emergency medical assistance or exceed the scope of medical assistance necessary and sufficient to diagnose an acute condition, eliminate a threat to life and stabilise the condition of the Insured Person shall not be reimbursed.

Planned, Preventive and Diagnostic (Screening) Medical Services Not Necessitated by the Need for Emergency Medical Assistance.

5.3.2. Expenses for the following shall not be reimbursed:

1) routine medical consultations, examinations, monitoring and treatment;

2) preventive medical examinations and dispensary check-ups;

3) medical commissions, medical examinations and expert medical assessments;

4) examinations and medical certificates required for employment, admission to educational institutions, military service, or enrolment in preschool or school institutions;

5) examinations and medical certificates required for participation in sporting events;

6) examinations required to obtain a visa, entry permit or residence permit in another country;

7) examinations required to obtain a driving license, a permit to carry weapons, or a deferment from or exemption from military service;

8) preventive vaccination, revaccination, immunization and disinfection;

9) genetic testing, screening and other examinations not necessitated by the need for emergency medical assistance;

10) medical services not prescribed by the attending physician;

11) medical procedures, examinations and tests that are not necessary for the diagnosis and treatment of the condition that gave rise to the need for emergency medical assistance;

12) repeat consultations, tests and examinations for which there are no medical indications;

13) services and medicinal products prescribed after the Insured Person's condition has stabilized for prolonged or routine treatment.

5.3.3. If the above diagnostic procedures were performed to determine the cause of an acute condition but revealed a disease or condition excluded from insurance coverage, the expenses for such diagnostic procedures:

1) shall not be reimbursed if the symptoms and circumstances giving rise to the request for medical assistance are directly related to a disease or condition previously diagnosed and excluded from insurance coverage under these Rules and the Insurance Contract;

2) may be reimbursed within the limit specified in the Insurance Contract if the disease had not been previously diagnosed, the symptoms objectively necessitated an emergency examination, and the excluded nature of the disease could not have been established before the diagnostic procedures were performed.

Dental Services:

5.3.4. Expenses for dental care shall not be reimbursed, except for emergency dental care expressly provided for in the Insurance Contract.

5.3.5. Emergency dental care does not include:

1) dental prosthetics;

2) manufacture or repair of dental prostheses;

3) fitting of crowns, veneers and implants;

4) orthodontic treatment;

5) routine treatment of teeth and gums;

6) professional dental cleaning, teeth whitening and other cosmetic procedures;

7) completion of treatment after the acute pain has been relieved;

8) treatment costs exceeding the limit specified in the Insurance Contract.

Rehabilitation and Alternative Treatment:

5.3.6. Expenses shall not be reimbursed for:

1) spa treatment;

2) treatment at holiday centers, boarding houses, sanatoriums and other sanatorium-type or health-improvement facilities;

3) restorative and rehabilitation treatment;

4) physiotherapy;

5) therapeutic exercise;

6) massage;

7) manual therapy;
8) homeopathy;
9) acupuncture;
10) naturopathy and other alternative or traditional folk methods of treatment;
11) services provided by a psychologist or psychotherapist, unless expressly provided for in the Insurance Contract.

Cosmetic and Reconstructive Services:

5.3.7. Expenses shall not be reimbursed for:

1) cosmetic procedures;
2) plastic and cosmetic surgery;
3) operations and procedures performed primarily for the purpose of changing appearance;
4) correction of cosmetic defects;
5) reconstructive surgery, except for emergency surgical intervention necessitated by an accident and expressly provided for in the Insurance Contract.

Medical Devices and Personal Care Products:

5.3.8. Expenses shall not be reimbursed for the purchase, rental, manufacture, replacement, repair or adjustment of:

1) spectacles, frames and contact lenses;
2) hearing aids and auditory implants;
3) dental, orthopaedic and other prostheses;
4) implants, metal fixation devices and endoprostheses;
5) orthopaedic footwear;
6) wheelchairs;
7) rehabilitation aids and patient care products;
8) medical equipment intended for long-term home use;
9) other corrective medical devices and appliances.

5.3.9. Crutches, canes, braces, orthoses, splints and other temporary immobilization and mobility aids may be covered if they:

1) are prescribed by the attending physician;
2) are directly necessary in connection with a covered injury;
3) are necessary for the discharge, mobility or transportation of the Insured Person;
4) are not intended for long-term rehabilitation;
5) are paid for within the limit specified in the Insurance Contract.

Medical Transportation and Evacuation:

5.3.10. Expenses shall not be reimbursed for medical transportation or evacuation:

1) not organized or approved by the Medical Assistance Provider, where prior approval was objectively possible;
2) not necessitated by medical indications;
3) in cases of illness or injury that can be safely treated at the place of temporary stay and do not prevent the Insured Person from returning independently;
4) chosen by the Insured Person based on personal preferences rather than medical necessity;
5) to the extent that they exceed the cost of the mode of transportation selected or approved by the Medical Assistance Provider;
6) for business-class or first-class travel, charter flights or special flights, unless such transportation is medically necessary and approved by the Medical Assistance Provider;

7) for an accompanying person, unless their accompaniment is prescribed by the attending physician and approved by the Medical Assistance Provider.

5.3.11. The restriction provided for in subparagraph 1) of paragraph 5.3.10 of this Article shall not apply if:

1) any delay posed an immediate threat to the life or health of the Insured Person;

2) it was objectively impossible to contact the Medical Assistance Provider;

3) the initial medical facility did not have the necessary specialists, medicines or equipment;

4) the transportation was arranged by public emergency services.

Repatriation

5.3.12. Expenses for repatriation shall not be reimbursed if death occurred:

1) as a result of an illness, injury or condition excluded from insurance coverage under these Insurance Rules and/or the terms of the Insurance Contract;

2) as a result of an illness or injury that occurred before the commencement of insurance coverage;

3) during a trip undertaken for the purpose of obtaining medical treatment;

4) if the death occurred outside the period and/or territory of insurance coverage.

5.3.13. The fact that the deceased Insured Person had a disability or a chronic or oncological disease shall not, in itself, constitute grounds for refusing payment for posthumous repatriation, provided that the Insured Person's death resulted from another cause recognized as an insured event.

5.3.14. The following expenses shall also not be reimbursed:

1) religious and ceremonial rites associated with the burial (funeral) of the Policyholder/Insured Person;

2) funeral arrangements;

3) purchase of a burial plot;

4) manufacture and installation of a monument;

5) travel and accommodation expenses of relatives of the deceased Insured Person, unless such expenses are expressly provided for in the Insurance Contract;

6) expenses exceeding the cost of the method of repatriation arranged or approved by the Medical Assistance Provider.

Additional Comfort and Ancillary Medical Expenses:

5.3.15. Expenses shall not be reimbursed for:

1) accommodation in a higher-comfort hospital room, unless medically necessary;

2) services for the purchase or use of a television, telephone, internet access, air conditioning and other household appliances;

3) hairdresser, cosmetologist and massage therapist services;

4) special or upgraded meals, except for therapeutic meals included in the cost of inpatient treatment;

5) interpreter services, except where expressly provided for in the Insurance Contract;

6) taxi fares, hotel accommodation and other personal expenses, unless reimbursement thereof is expressly provided for in the Insurance Contract;

7) administrative fees and commissions not included in the cost of covered medical services;

8) services received after the date on which the Insured Person's condition permitted continuation of treatment at their place of permanent residence or an agreed evacuation.

Indirect Expenses and Property Losses:

5.3.16. The following expenses shall not be reimbursed:

1) non-pecuniary damage;

2) loss of profit;
3) loss of income or earnings;
4) commercial losses;
5) fines, penalties, default interest and other financial sanctions;
6) expenses associated with the loss of or damage to property;
7) the cost of unused tickets, bookings, travel services and accommodation, unless such coverage is expressly provided for in the Insurance Contract;
8) telephone and internet expenses, except for communication with the Medical Assistance Provider, where reimbursement of such expenses is expressly provided for in the Insurance Contract;
9) expenses not supported by documents sufficient to establish the nature of the service, the date on which it was provided, its cost and the fact of payment;
10) any portion of expenses exceeding the sum insured, the applicable limit or sublimit, unless expressly provided otherwise in the Insurance Contract;
11) the amount of the unconditional deductible specified in the Insurance Contract;
12) expenses reimbursed by a medical facility, carrier, tour operator, government authority, compulsory health insurance system, another insurer or a third party.

5.4. Grounds for Full or Partial Refusal of Insurance Payment:

5.4.1. The Insurer shall be entitled to refuse, in whole or in part, to make an insurance payment if the insured event occurred as a result of:

1) willful acts of the Policyholder, Insured Person or Beneficiary intended to cause the insured event or contributing to its occurrence, except for acts committed in a state of self-defense or necessity;

2) acts of the Policyholder, Insured Person or Beneficiary recognized, in accordance with the procedure established by the legislation of the Republic of Kazakhstan, as an intentional criminal or administrative offence causally related to the insured event.

5.4.2. The following shall also constitute grounds for full or partial refusal of an insurance payment:

1) the provision by the Policyholder, Insured Person or Beneficiary of knowingly false information regarding the subject matter of insurance, state of health, insured risk, insured event, its causes, circumstances and consequences, or the scope, nature or cost of services rendered;

2) the submission of false, altered or inaccurate documents;

3) a claim for reimbursement of services that were not actually provided;

4) a claim for reimbursement of expenses that were not actually incurred;

5) deliberate overstatement of the amount of expenses claimed;

6) willful failure to take reasonable and available measures to reduce expenses associated with the insured event;

7) obstruction of the Insurer or Medical Assistance Provider in establishing the occurrence, causes and circumstances of the insured event or the amount of expenses;

8) refusal to provide documents and information available to the claimant (Policyholder/Insured Person/Beneficiary) that are necessary for consideration of the insurance payment claim;

9) refusal to consent to the disclosure of medical information to the extent necessary for consideration of the insured event, where it is impossible to establish the diagnosis, circumstances of the event or amount of expenses without such information;

10) unjustified refusal by the Insured Person to undergo a medical examination or diagnostic procedure prescribed to confirm the circumstances of the insured event, where such examination or procedure is objectively feasible, necessary and paid for by the Insurer.

11) failure to notify, or late notification to, the Medical Assistance Provider or the Insurer of the event in accordance with the procedure and within the time limits stipulated in these Rules, where such failure or delay deprived the Insurer of the opportunity to establish the circumstances of the event, arrange medical assistance or resulted in an unjustified increase in expenses;

12) receipt of medical services without prior approval from the Medical Assistance Provider;

13) reimbursement of the relevant expenses by a medical facility, carrier, tour operator, another insurer, a government authority or another third party;

14) failure to submit the claim and supporting documents within the time limit established by these Rules, where the delay was not due to valid reasons and resulted in the Insurer losing the opportunity to establish the occurrence, causes and circumstances of the event or the amount of expenses;

15) use of the insurance policy by a third party or submission of documents relating to medical assistance provided to a third party;

16) other grounds expressly provided for by the applicable legislative acts of the Republic of Kazakhstan.

5.4.3. Failure to provide a document shall not constitute grounds for refusal to make an insurance payment if:

1) the document provided by the Insured Person does not relate to the reported event that has the characteristics of an insured event;

2) the relevant information and/or documents are available to the Insurer or the Medical Assistance Provider;

3) the document can be obtained by the Insurer from a state or other information system;

4) obtaining the document is objectively impossible for reasons beyond the control of the Policyholder, Insured Person or Beneficiary;

5) the circumstances that the document is intended to confirm can be established on the basis of other reliable evidence.

5.4.4. Failure to notify, including late notification, shall not constitute grounds for refusal if:

1) the Insured Person was unconscious, in a serious condition or in another condition that prevented notification;

2) notification was impossible due to lack of communication facilities, an emergency or other objective circumstances;

3) the Insurer or the Medical Assistance Provider was notified of the event in a timely manner through other sources;

4) the failure to comply with the notification deadline did not affect the ability to establish the circumstances of the insured event and the amount of expenses incurred.

5.4.5. If unjustified failure to approve services, refusal of evacuation, failure to comply with medical instructions or failure to take measures to reduce expenses resulted only in an increase in the cost of treatment, the Insurer shall be entitled to refuse payment only in respect of such increase.

5.4.6. If it is established that a service was medically necessary for the provision of emergency medical assistance, but its cost exceeds the usual cost of a comparable service at the place where it was provided, the Insurer shall be entitled to limit the insurance payment to the documented and substantiated cost of a comparable medical service. Such reduction shall be supported by data from the medical facility, the Medical Assistance Provider or other objective information regarding the cost of services.

5.4.7. When making a decision to refuse an insurance payment, the Insurer shall notify the Policyholder (Insured Person, Beneficiary) of the decision in writing, stating the reasons for the refusal, within 15 (fifteen) business days from the date of the decision, unless otherwise provided for in the Insurance Contract.

5.4.8. The Insurer's decision on full or partial refusal of an insurance payment shall be made in writing and shall contain the following:

1) the established circumstances of the event;

2) a list of the documents reviewed;

3) the specific grounds for refusal;

4) a reference to the relevant clause of these Rules, the Insurance Contract and the applicable provision of the legislation of the Republic of Kazakhstan;

5) the reasons substantiating the causal link between the established circumstances and the refusal or reduction of the insurance payment;

6) a calculation of the portion of expenses for which reimbursement has been refused;

7) information on the right of the Policyholder (Insured Person, Beneficiary) to apply to the insurance ombudsman (from 1 January 2027, the financial ombudsman) to settle disputes, subject to the specific requirements of the legislation of the Republic of Kazakhstan.

In the event of a dispute between the parties regarding the causes and amount of loss, either party shall be entitled to request an expert examination. The expert examination shall be conducted at the expense of the party requesting it. If the expert examination establishes that the Insurer's refusal to pay a portion of the insurance indemnity was unjustified, the Insurer shall bear a share of the expert examination costs proportionate to the ratio between the amount initially refused and the amount of the insurance payment made following the expert examination.

5.4.9. The burden of proving the circumstances serving as grounds for full or partial refusal shall lie with the Insurer, except for the obligation of the claimant (Policyholder/Insured Person/Beneficiary) to prove the occurrence of the insured event and the amount of expenses claimed.

5.4.10. If, after an insurance payment has been made, it is established that the payment was obtained on the basis of knowingly false information or forged documents, or in the absence of entitlement to such payment, the Insurer shall be entitled to demand repayment of the amount unduly received and compensation for losses in accordance with the procedure established by the applicable legislation of the Republic of Kazakhstan.

5.5. Restrictions Related to Anti-Money Laundering, Counter-Terrorist Financing and Sanctions Requirements

5.5.1. The Insurer shall identify and conduct due diligence on the Policyholder, Insured Person, Beneficiary, their representatives and beneficial owners in the cases and in accordance with the procedure provided for by the legislation of the Republic of Kazakhstan on anti-money laundering, counter-terrorist financing and counter-proliferation financing (AML/CFT and FPWMD).

5.5.2. The Policyholder, Insured Person, Beneficiary and their representatives shall, at the Insurer's request, provide information and documents necessary for:

1) identification of the relevant person;

2) verification of the representative's authority;

3) identification of the beneficial owner;

4) establishment of the source of funds for a transaction in cases provided for by law;

5) determination of the purpose and nature of the business relationship;

6) verification of whether the person is included in the lists provided for by law;

7) compliance with other due diligence requirements.

5.5.3. The Insurer shall be entitled not to establish a business relationship, to refuse to conclude the Insurance Contract or to terminate a business relationship where:

1) it is impossible to conduct due diligence on the client, their representative or beneficial owner;

2) the client has refused to provide the information and documents required for due diligence;

3) the information and documents provided by the client are unreliable or insufficient to complete due diligence;

4) other grounds for refusing to establish or continue a business relationship, as provided for by the legislation of the Republic of Kazakhstan, exist.

5.5.4. If the Policyholder, Insured Person, Beneficiary, their representative or beneficial owner is included in the list of organizations and persons associated with the financing of terrorism and extremism, or in the list of persons and organizations associated with the financing of the proliferation of weapons of mass destruction, the Insurer shall apply measures to freeze transactions involving money and other property in accordance with the procedure and within the limits established by the legislation of the Republic of Kazakhstan.

5.5.5. The inclusion of a person in the aforementioned list shall not alter the classification of the event as an insured or non-insured event. However, any monetary transaction, including an insurance payment, shall be carried out, suspended, frozen or not carried out in accordance with the mandatory requirements of the legislation of the Republic of Kazakhstan and the decisions of the authorized body.

5.5.6. The Insurer shall be entitled to refuse to conduct a transaction, suspend its execution, freeze money or other property, or terminate business relationships only in the cases and in accordance with the procedure provided for by the legislation of the Republic of Kazakhstan.

5.5.7. The Insurer's suspicion that a transaction may be associated with money laundering, terrorist financing or the financing of the proliferation of weapons of mass destruction shall not, in itself, constitute a final decision to refuse an insurance payment on the merits of the insured event.

5.5.8. In addition to the grounds for exemption from making an insurance payment established by the legislation of the Republic of Kazakhstan and these Rules, the Insurer shall be obliged to refuse an insurance payment in the following cases:

1) the Policyholder/Insured Person/Beneficiary and/or beneficial owner being included in the list of organizations and persons associated with the financing of terrorism and extremism published on the official website of the Agency of the Republic of Kazakhstan for Financial Monitoring, or in the list of persons and organizations associated with the financing of the proliferation of weapons of mass destruction (FPWMD);

2) failure by the Policyholder/Insured Person to provide documents and additional information requested by the Insurer for due diligence in accordance with the requirements of the Law of the Republic of Kazakhstan "On Counteracting the Legalization (Laundering) of Proceeds from Crime, the Financing of Terrorism and the Financing of the Proliferation of Weapons of Mass Destruction";

3) where there are grounds to believe that a transaction involving money and/or other property is being carried out for the purpose of money laundering, terrorist financing or the financing of the proliferation of weapons of mass destruction (AML/CFT and FPWMD);

4) where sanctions, prohibitions or restrictions imposed by United Nations resolutions, or trade or economic sanctions, laws or regulations of the European Union/European Economic Area, the United Kingdom or the United States, or any other national economic or trade sanctions, laws or restrictions in force or applicable at the relevant time, including at the time of the insured event, have been applied to or imposed on the Policyholder/Insured Person/Beneficiary or their affiliated persons.

Where grounds for refusal of an insurance payment exist, the Insurer shall, within 3 (three) business days from the date of receipt of the Beneficiary's request for an insurance payment, send the Beneficiary a written decision refusing the insurance payment, stating the reasons for the refusal and providing a reasoned justification thereof.

Article 6. PROCEDURE FOR DETERMINING THE SUM INSURED

6.1. The sum insured is the amount of money for which the subject matter of insurance is insured and which represents the maximum extent of the Insurer's liability upon the occurrence of an insured event.

6.2. The sum insured shall be determined based on the list and cost of expenses and services covered by insurance and specified in the Insurance Contract.

6.3. The Insurance Contract may specify:

– an aggregate limit of liability, in which case the total amount of all insurance payments for all insured events throughout the entire term of the Insurance Contract shall not exceed that limit;

– a limit of liability per one or more insured events;

– a limit of liability per one or more insured risks, per one or more expenses and services covered by insurance, or per one or more insured events.

6.4. The currency of the sum insured shall be the tenge (KZT). The sum insured shall be specified in the Insurance Contract using a fixed equivalent in a foreign currency (USD/EUR), calculated at the official exchange rate of the National Bank of the Republic of Kazakhstan as at the date of conclusion of the Insurance Contract.

Article 7. INSURANCE PREMIUM.

7.1. The insurance premium shall be established by the Insurance Contract and means the amount of money that the Policyholder is obliged to pay to the Insurer in consideration of the latter assuming the obligation to make an insurance payment upon the occurrence of an insured event.

7.2. The Insurance Contract shall specify the total insurance premium. The Insurance Contract may also specify the insurance premium for each Insured Person, where applicable.

7.3. The amount of the insurance premium payable under the Insurance Contract shall be calculated in accordance with the insurance rates, which determine the insurance tariff rate charged per unit of the sum insured, taking into account the specific insurance terms and conditions, including the insurance period, age and number of Insured Persons, territory of insurance coverage, sum insured, purpose of travel and adjustment coefficients.

7.4. The insurance premium shall be paid by the Policyholder either in a single payment or in instalments in the form of periodic insurance contributions, in cash or by bank transfer, in accordance with the Insurance Contract.

7.5. If the Policyholder fails to pay the insurance premium within the time limits stipulated in the Insurance Contract or delays payment of any instalment by more than 3 (three) calendar days in accordance with the payment schedule specified in the Insurance Contract, the Insurer shall be entitled to recover the full amount of the insurance premium for the entire insurance period through legal proceedings.

7.6. If an insured event occurs before payment of a due insurance instalment (insurance premium) that is overdue, the Insurer shall be entitled to refuse to make an insurance payment. Insurance payments in respect of subsequent insured events shall be made subject to payment of the insurance premium in full.

7.7. The date of payment of the insurance premium (or the relevant insurance instalment) shall be the date on which the funds are credited to the Insurer's bank account or received by its cash office.

Article 8. DEDUCTIBLE

8.1. The Insurance Contract may provide for an unconditional deductible by mutual agreement of the parties.

8.2. An unconditional deductible shall be deducted from the amount of the insurance payment for each and every insured event, irrespective of the amount of loss and the sum insured.

8.3. The deductible may be set either as a percentage of the sum insured or as a fixed amount.

Article 9. INSURANCE CONTRACT EXECUTION PROCEDURE

9.1. The Insurance Contract shall be concluded subject to compliance with the requirements for conducting due diligence in accordance with the Insurer's "Internal Control Rules for Counteracting the Legalisation (Laundering) of Proceeds from Crime, the Financing of Terrorism and the Financing of the Proliferation of Weapons of Mass Destruction".

9.2. Prior to the conclusion of the Insurance Contract, the Policyholder shall notify the Insurer:

1) if the Policyholder (Insured Person, Beneficiary, representative and/or beneficial owner) is a politically exposed person, their spouse or close relative;

2) if the beneficial owner of a legal entity is another person (other than the Policyholder, where the Policyholder is a legal entity);

3) that the transaction being carried out by the Policyholder is not related to money laundering, terrorist financing or the financing of the proliferation of weapons of mass destruction (AML/CFT and FPWMD). Where necessary, the Policyholder undertakes to provide all documents requested by the Insurer for the purpose of complying with the requirements of the legislation of the Republic of Kazakhstan on AML/CFT and FPWMD.

9.3. The Insurance Contract shall be concluded in writing by the Policyholder acceding to these Insurance Rules, unilaterally developed by the Insurer (contract of adhesion), and by the Insurer issuing an insurance policy to the Policyholder on the basis of an insurance application form signed by the Policyholder in the form prescribed by the Insurer.

9.4. The Insurance Contract may be concluded electronically by exchanging electronic information resources between the Policyholder and the Insurer using the Insurer's Internet resource and/or the Internet resources of other organizations that are partners of the Insurer. When concluding the Insurance Contract using the Internet resource of the Insurer or its partner, the Policyholder shall pay the insurance premium (or the first insurance instalment where the premium is payable in instalments) after reviewing these Rules, thereby confirming their consent to conclude the Insurance Contract by acceding to these Insurance Rules, unilaterally developed by the Insurer (contract of adhesion), on the terms offered.

9.5. The insurance application form shall constitute an integral part of the Insurance Contract.

9.6. When entering into the Insurance Contract, the Policyholder shall inform the Insurer of all circumstances known to the Policyholder that are material to determining the likelihood of an insured event occurring and the amount of potential losses arising therefrom (insured risk), provided that such circumstances are not and should not be known to the Insurer.

The following circumstances shall be deemed material:

1) the surname, first name and patronymic (if any), or the full name of the Policyholder, if the Policyholder is a legal entity;

2) the place of residence or registered address, telephone number, fax number and banking details;

3) details of the Insured Person;

4) the insurance period;

5) the territory of insurance coverage;

6) the existence and nature of any chronic diseases, current health disorders, disability or pregnancy of the Insured Person at the time of conclusion of the Insurance Contract;

7) the age of the Insured Person at the time of conclusion of the Insurance Contract;

8) the types of sports, active leisure and other professional and/or amateur activities associated with an increased risk to the life and health of the Insured Person that are planned during the trip;

9) whether the Insured Person is within the territory of insurance coverage (outside the territory of the Republic of Kazakhstan) at the time of conclusion of the Insurance Contract;

10) whether the Policyholder/Insured Person has any other similar voluntary insurance contracts

in force;

11) the list of insured events against which insurance coverage is provided;

12) the sum insured;

13) the term of the Insurance Contract;

14) the procedure for payment of the insurance premium (in a single payment or in instalments);

15) the existence of losses;

16) any other information specified in the insurance application form.

9.7. If, after conclusion of the Insurance Contract, it is established that the Policyholder knowingly provided the Insurer with false information regarding the circumstances specified in Clause 9.6 of these Insurance Rules, the Insurer shall be entitled to demand that the Insurance Contract be declared invalid or to refuse to make an insurance payment upon the occurrence of an insured event. The Insurer may not demand that the Insurance Contract be declared invalid if the circumstances concealed by the Policyholder no longer exist.

9.8. Where necessary, the Policyholder shall attach documents identifying the Insured Person and confirming their age, as well as documents confirming the dates and itinerary of the planned trip and the lawfulness of the Insured Person's stay within the territory of insurance coverage.

9.9. Amendments and additions to an insurance policy shall not be permitted. Any changes to the terms of an insurance policy shall be effected by terminating the existing policy and concluding a new insurance policy.

Article 10. TERM AND TERRITORIAL SCOPE OF THE INSURANCE CONTRACT

10.1. The Insurance Contract shall be concluded for a period of 12 (twelve) months, unless otherwise provided for in the Insurance Contract.

10.2. The Insurance Contract shall enter into force on the day following the date on which the insurance premium or the first insurance instalment is credited to the Insurer's bank account or paid into its cash office, unless otherwise provided for in the Insurance Contract.

10.3. The period of insurance coverage shall coincide with the term of the Insurance Contract, unless otherwise provided for in the Insurance Contract.

10.4. The Insurance Contract shall expire at the end of the last day of its term.

10.5. The Insurance Contract shall apply exclusively within the territory specified in the Insurance Contract (territory of insurance coverage).

10.6. The Insurance Contract shall be concluded for a single trip abroad or for a specified period covering multiple trips outside the territory of the Republic of Kazakhstan, but for no longer than 1 (one) calendar year (12 months).

10.7. Where insurance is provided under the "Multi Trip" program, which covers multiple trips abroad by the Insured Person, insurance coverage shall apply during the Insured Person's actual stay abroad. The actual number of days for which the Insurance Contract provides coverage shall be specified in the Insurance Contract.

Article 11. RIGHTS AND OBLIGATIONS OF THE PARTIES

11.1. The Insurer shall have the right to:

1) verify the information and documents provided by the Policyholder, as well as compliance with the terms of the Insurance Contract;

2) request the documents necessary to conduct due diligence on the client in accordance with the Insurer's Internal Control Rules for Counteracting Money Laundering, Terrorist Financing and the Financing of the Proliferation of Weapons of Mass Destruction (AML/CFT and FPWMD);

3) terminate the business relationship with the Policyholder if, in the course of reviewing transactions carried out by the Policyholder (or their representative), beneficial owner, Insured

Person or Beneficiary, suspicions arise that the Policyholder is using the business relationship for the purposes of money laundering, terrorist financing or the financing of the proliferation of weapons of mass destruction (AML/CFT and FPWMD);

4) obtain from the Policyholder information on circumstances material to determining the likelihood of an insured event occurring and the amount of potential loss (insured risk);

5) demand payment of the insurance premium if the Policyholder breaches the terms governing payment of insurance instalments where the premium is payable in instalments, as well as repayment of an insurance payment made in the cases provided for by the Insurance Contract and the legislation of the Republic of Kazakhstan;

6) terminate the Insurance Contract early and recover losses incurred as a result of the Policyholder's failure to fulfil their obligations;

7) demand termination of the Insurance Contract if the Policyholder fails to notify the Insurer of material changes in circumstances disclosed to the Insurer at the time of conclusion of the Insurance Contract, where such changes may significantly increase the insured risk, or if the Policyholder objects to amendments to the Insurance Contract or to paying an additional premium proportionate to the increase in the degree of risk;

8) require the Policyholder/Insured Person to provide documents confirming the occurrence of an insured event, including medical and accounting documents issued by a foreign medical facility, with a notarized translation into Kazakh and/or Russian;

9) where necessary, refer the Insured Person for a medical examination when concluding the Insurance Contract;

10) discontinue the instalment payment arrangement for the insurance premium if an insured event occurs before the next or final payment is made.

11) where necessary, submit requests to the competent authorities for relevant documents and information confirming the occurrence, causes and circumstances of the insured event and the amount of loss incurred. If the competent authorities hold materials providing grounds for the Insurer to refuse an insurance payment, defer the payment until the Insurer receives official responses or supporting information from the competent authorities;

12) refuse to make an insurance payment, reduce the amount thereof or defer payment on the basis of information and documents provided by authorized bodies, in accordance with the Insurance Contract and the applicable legislation of the Republic of Kazakhstan;

13) refuse to make an insurance payment if the documents confirming the occurrence of the insured event and the amount of loss, as specified in Article 13 of these Rules, have not been provided within 90 calendar days from the date on which the claim notification was submitted to the Insurer;

14) take other actions that do not contravene the applicable legislation of the Republic of Kazakhstan.

11.2. The Insurer shall:

1) familiarize the Policyholder with these Insurance Rules and, upon request, provide or send a copy of the Rules and the terms of the Insurance Contract;

2) provide the Policyholder with the opportunity to independently review the Insurance Rules on the Insurer's Internet resource;

3) register the notification of an insured event;

4) upon the occurrence of an insured event, make an insurance payment in the amount and in accordance with the procedure and time limits established by the Insurance Contract;

5) ensure the confidentiality of insurance-related information and other information protected by the legislation of the Republic of Kazakhstan;

6) if the Policyholder/Beneficiary fails to submit the complete set of documents required for the Insurer to make a decision on the insurance payment, notify the Policyholder/Beneficiary in

writing of the missing documents within 15 (fifteen) calendar days from the date of receipt of the last document, unless another period is provided for in the Insurance Contract;

7) make an insurance payment or send the Policyholder a written, reasoned refusal to make an insurance payment in accordance with the terms of the Insurance Contract;

8) reimburse the Policyholder for expenses incurred to reduce losses upon the occurrence of an insured event;

9) notify the Policyholder, by electronic message, of the conclusion of the Insurance Contract or the refusal to conclude it (stating the reasons for refusal), where the contract is concluded via the Insurer's or its partner's Internet resource;

10) ensure the protection and security of personal data and insurance-related information, and prevent access by third parties, including the owner of the electronic terminal, to information transmitted to the Insurer's Internet resource via the electronic terminal;

11) after 60 calendar days from the date on which the claim notification was submitted to the Insurer, notify the Policyholder/Beneficiary by sending a reminder to their email address or delivering it in person to the address specified in the notification, of the need to provide the Insurer with the required documents;

12) monitor the scope, timing and quantity of services provided in accordance with the terms of the Insurance Contract;

13) perform other actions provided for by the Insurance Contract and the applicable legislation of the Republic of Kazakhstan.

11.1. The Policyholder shall have the right to:

1) request the Insurer to clarify the terms of insurance and the rights and obligations established by these Rules and the Insurance Contract, and to obtain a copy of these Insurance Rules in hard copy or scanned form, or a link to the publication of the Insurance Rules on the Insurer's or its partner's Internet resource;

2) obtain a duplicate of the Insurance Contract in the event of its loss, upon submission of a written application;

3) amend the list of Insured Persons before the occurrence of an insured event. To amend the list of Insured Persons, the Policyholder shall submit a written application to the Insurer in advance, at least 3 (three) days before the intended date of the amendments. Such application shall constitute an integral part of the Insurance Contract (insurance policy);

4) amend the terms of the Insurance Contract by agreement with the Insurer, including changes to the insured risk with a corresponding adjustment of the insurance premium;

5) receive an insurance payment in the amount and in accordance with the procedure and time limits provided for in the Insurance Contract, if the Policyholder is the Beneficiary;

6) terminate the Insurance Contract early;

7) challenge the Insurer's refusal to make an insurance payment or reduction of the amount thereof in accordance with the procedure established by the legislation of the Republic of Kazakhstan;

8) perform other actions that do not contravene the applicable legislation of the Republic of Kazakhstan.

11.4. The Policyholder (Insured Person) shall:

1) when concluding the Insurance Contract, including via the Insurer's Internet resource, disclose to the Insurer all circumstances known to them that are material to the assessment of the insured risk;

2) inform the Insurer, both upon conclusion of the Insurance Contract and throughout its term, of all similar insurance contracts in force or being concluded;

3) provide all documents and information requested by the Insurer for the purpose of conducting due diligence on the Policyholder;

4) notify the Insurer of any increase in the insured risk or any material changes in the circumstances disclosed at the time of conclusion of the Insurance Contract, where such changes may increase the risk during the term of the insurance policy;

5) familiarize themselves with the Insurance Rules published on the Insurer's Internet resource;

6) pay insurance premiums in the amount and in accordance with the procedure and time limits established by the Insurance Contract;

7) take all possible and reasonable measures to prevent or reduce losses arising from an insured event, inform the Insured Persons of the requirements of these Insurance Rules, and comply with the terms of the Insurance Rules. Any breach of the Insurance Rules by an Insured Person shall be treated as a breach of the insurance terms by the Policyholder;

8) notify the Insurer of the occurrence of an event that has the characteristics of an insured event, in accordance with the procedure and within the time limits established by these Insurance Rules;

9) provide the Insurer with all information available to them that may help establish the causes, course and consequences of the insured event, as well as the nature and amount of the loss incurred;

10) bear the burden of proving the occurrence of the insured event and the loss incurred;

11) repay to the Insurer the insurance payment received, in whole or in part, within one month if, within the limitation periods prescribed by the applicable legislation of the Republic of Kazakhstan, circumstances are discovered which, under the applicable legislation of the Republic of Kazakhstan and the Insurance Contract, fully or partially deprive the Policyholder or Beneficiary of the right to receive the insurance payment;

12) person responsible for the occurrence of the insured event;

13) upon receipt of an insurance payment, the Policyholder shall not be entitled to recover compensation for the loss from the person at fault, except where the insurance payment does not fully cover the loss incurred. In such case, the Policyholder shall be entitled to recover from the person at fault the outstanding difference between the insurance payment and the amount of the loss;

14) repay the insurance payment and compensate for the losses incurred in the event of a breach of subparagraph 13) of paragraph 10.4 of these Insurance Rules;

15) obtain the consent of the Insured Person/Beneficiary to the conclusion of the Insurance Contract and their consent to the collection and processing of personal data, including cross-border transfer of personal data, as well as to the transfer of data to and receipt of data from the unified insurance database for the purpose of exchanging information with government databases. Personal data shall be stored for a period determined by the Insurer, for as long as their further storage is necessary, and for a period of 10 years. Personal data shall be used for the purpose of enabling the Insurer or a third party to fulfil the terms of the Insurance Contract and/or comply with the requirements of the legislation of the Republic of Kazakhstan, as well as to pursue the Insurer's business objectives as a whole;

16) upon conclusion of the Insurance Contract, the Policyholder (Insured Person) shall confirm and provide their consent, and ensure that consent is obtained from the Insured Persons (including minors), to release doctors and other medical facility personnel, as well as the Insurer, from their obligations to maintain confidentiality, insurance secrecy and medical confidentiality vis-à-vis the Insurer, the carrier, other medical facilities and third parties involved in making the insurance payment and providing services, to the extent related to the insured event and necessary for the performance of the Insurance Contract. Where necessary, the Policyholder undertakes to provide written authorisation to doctors, medical organisations and other authorised persons, both in the country of permanent residence (citizenship) and within the territory of insurance coverage, to provide the Insurer, upon request, with documents (certificates, reports, opinions, etc.) and information necessary to investigate the circumstances of the insured event, and to transmit such documents and information for the purpose of fulfilling the terms of the Insurance Contract.

Article 12. ACTIONS TO BE TAKEN BY THE POLICYHOLDER (INSURED PERSON) IN THE EVENT OF AN INSURED EVENT

12.1. The burden of proving the occurrence of an insured event and the losses incurred as a result thereof shall lie with the Policyholder/Insured Person.

12.2. Upon the occurrence of any event that has the characteristics of an insured event, that is, before seeking medical assistance or any other additional assistance specified in the Insurance Contract, the Policyholder/Insured Person shall contact the Assistance Provider immediately, but no later than 24 (twenty-four) hours from the occurrence of such event, using the telephone numbers specified in the Insurance Contract.

12.3. When contacting the Assistance Provider, the following information shall be provided:

1) the surname, first name and patronymic of the Insured Person requiring medical assistance;

2) the date of birth of the Insured Person;

3) the contact telephone number of the Insured Person for follow-up communication;

4) the country, region and city of stay, the name of the hotel (address of the apartment) where the Insured Person is located;

5) details of the Insurance Contract (number, date of conclusion and term of validity);

6) the reason for contacting the Assistance Provider.

12.4. The Insured Person shall act in accordance with the instructions received from the Assistance Provider.

12.5. Upon the occurrence of an insured event covered by the Insurance Contract, the Assistance Provider, acting on behalf of the Insurer, shall arrange the provision of medical and other services to the Insured Person as provided for in these Insurance Rules, within the sum insured or the limits established by the Insurance Contract. The services provided by the Assistance Provider shall be limited to the scope necessary and sufficient for the provision of emergency medical assistance, taking into account the deductible specified in the Insurance Contract.

12.6. If the Assistance Provider is not notified within the period specified in Clause 12.2 of this Article and the Policyholder/Insured Person is already receiving emergency medical assistance, the Policyholder/Insured Person or their representative shall notify the Assistance Provider of the following information immediately, but no later than 24 (twenty-four) hours from the time emergency medical assistance was sought:

1) the name, address and contact telephone number of the medical facility where the Policyholder/Insured Person is receiving emergency medical assistance;

2) the full name and contact telephone number of the attending physician;

3) details of the Insurance Contract (number, date of conclusion and term of validity).

12.7. The Policyholder/Insured Person shall thereafter:

1) take reasonable and available measures, in the circumstances, to reduce losses associated with the insured event, and, at the request of the Insurer and/or the Assistance Provider, provide the following documents: outpatient medical records, prescription forms, hospitalization referrals, reports, certificates and medical statements issued by the attending physician, and other documents relating to the insured event.

12.8. At the request of the Insurer or the Assistance Provider, originals of documents relating to the insured event shall be provided in Kazakh or Russian, or in the original language accompanied by a notarized translation into Kazakh or Russian.

12.9. In the event of the death of the Insured Person, the Policyholder, Beneficiary or their legal representatives shall be responsible for notifying the Insurer or the Service Company (Assistance Provider) of the occurrence of the insured event. Such notification shall be given within 7 (seven) calendar days from the date on which the aforementioned persons became aware of the Insured Person’s death.

12.10. Late notification by the Policyholder/Insured Person to the Service Company (Assistance Provider)/Insurer of the occurrence of an event that may result in an insured event shall entitle the Insurer to refuse to make an insurance payment, in whole or in part, except where the Policyholder (Insured Person) was unable to fulfil the aforementioned obligations for valid reasons and has provided documentary evidence thereof.

12.11. If the Policyholder/Insured Person has independently paid for medical services received in the country of temporary stay, the Policyholder/Insured Person shall, subject to compliance with these Insurance Rules and the Insurance Contract, submit the relevant documents to the Insurer no later than 1 (one) calendar month from the date of arrival in the Republic of Kazakhstan (the country of the Insured Person's permanent residence).

12.12. If, at the time of a visit or appointment arranged by the Assistance Provider, the Policyholder/Insured Person is absent from the specified location, any subsequent visit by the doctor and the services provided shall be arranged and paid for by the Insured Person. In such cases, the Service Company shall provide the address and contact details of a medical facility so that the Insured Person may seek medical assistance independently or arrange for a doctor to visit their place of stay. At the Insurer's request, the Insured Person shall reimburse the costs incurred in arranging a visit by a medical professional that did not take place due to the absence of the Policyholder/Insured Person.

12.13. If it is impossible to contact the Service Company (Assistance Provider), the Insured Person shall, as soon as they become aware of the occurrence of an event, but in any case no later than three (3) business days, excluding public holidays and weekends, calculated from the time they became aware of the event, notify the Insurer or its authorised representative of the insured event by any available means, provide all information known to them regarding the circumstances of the event, the types and estimated amounts of the loss incurred, agree on further actions with the Insurer, and subsequently submit a written notification using the form prescribed by the Insurer.

Article 13. LIST OF DOCUMENTS CONFIRMING THE OCCURRENCE OF AN INSURED EVENT AND THE AMOUNT OF LOSS

13.1. To receive an insurance payment, the Policyholder/Insured Person shall submit the following documents to the Insurer:

1) a copy of the insurance policy or a duplicate thereof (in the event of loss of the insurance policy);

2) originals of medical documents containing information on the diagnosis, the Insured Person's state of health at the time medical assistance was sought, the procedures performed and treatment provided, or a medical document relating to the accident;

3) originals of prescriptions, invoices and receipts for payment for medical services and medicines;

4) a copy of the Insured Person's international passport bearing stamps indicating the dates of crossing the state borders of the Republic of Kazakhstan and the country constituting the territory of insurance under the Insurance Contract;

5) documents identifying the Insured Person and confirming their entitlement to receive the insurance payment;

6) a copy of the birth certificate, where the Insured Person is a minor;

7) originals or copies of travel tickets;

8) the Beneficiary's bank account details;

9) in the event of an accident, documents confirming the occurrence and causes of the insured event:

- in the event of a road traffic accident (RTA) – originals or copies of reports issued by the traffic police and/or other competent authorities in the country of stay;

- in the event of harm caused by third parties – a decision recognizing the Insured Person as a victim and a report issued by the police and/or other competent authorities in the country of stay;

- in the event of a fire – a fire report.

10) At the Insurer's request, documents confirming outgoing calls/SMS messages to the Service Company for the purpose of notifying it of the insured event.

11) In the event of the Insured Person's death, the following additional documents shall be provided:

- notarized copies of documents prescribed by the legislative acts of the Republic of Kazakhstan containing information on the cause of the Insured Person's death (forensic medical examination report, etc.);

- the original or a notarized copy of the death certificate;

- the results of the post-mortem examination, at the Insurer's request;

- documents confirming the posthumous repatriation of the Insured Person (transport documents for the transportation of the deceased's remains, receipts and payment slips confirming the costs of embalming/treatment of the body and the cost of the coffin). Payment documents must be issued in the name of the Beneficiary. If the services were paid for by the Insured Person during their lifetime, the insurance payment shall be made to the person legally entitled to receive it, whose entitlement must be documented.

12) In the event of the evacuation of children and/or the urgent arrival of an accompanying person at the medical facility where the Insured Person is staying temporarily, the originals of travel tickets must be provided, provided that reimbursement of these expenses is stipulated in the Insurance Contract.

13) Documents confirming the occurrence and causes of the insured event, issued by the competent authorities (such documents include certificates, reports, records, resolutions, decisions and findings).

13.2. The documents listed in Clause 13.1 of these Insurance Rules shall be submitted to the Insurer with a translation into the state language, Russian or English. The costs of translating the documents shall be borne by the Policyholder (Insured Person).

13.3. At the Insurer's request, the Insured Person shall undergo a medical examination and submit the results thereof within three (3) business days from the date the request is issued, for the purpose of confirming the occurrence of the insured event and establishing the diagnosis.

13.4. Upon accepting the documents, the Insurer shall issue a receipt specifying the complete list of documents submitted and the date of their acceptance.

13.5. If the Policyholder/Insured Person/Beneficiary fails to submit all documents required for the insurance payment, the Insurer shall notify the applicant in writing, specifying the missing documents, within fifteen (15) calendar days from the date of submission of the last document.

Article 14. PROCEDURE, CONDITIONS AND TIME LIMIT FOR MAKING A DECISION ON THE PAYMENT OF INSURANCE INDEMNITY

14.1. Upon receipt of all documents required under Clause 13.1 of these Insurance Rules to make a decision on the insurance payment or refusal thereof, the Insurer shall, within fifteen (15) business days, make the insurance payment or refuse to make such payment, stating the reasons for the refusal.

14.2. If an insurance payment has already been made in respect of an insured event resulting in the Insured Person's death caused by the same accident, the amount of the insurance payment previously made in respect of that accident shall be deducted from the insurance payment payable in connection with the death.

14.3. The total amount of insurance payments made to the Insured Person in respect of the consequences of one or more insured events occurring during the term of the Insurance Contract

shall not exceed the aggregate sum insured established for each Insured Person.

14.4. The Insurer shall be entitled to refuse to make an insurance payment to the Policyholder, in whole or in part, if the insured event occurred as a result of:

1) intentional acts of the Policyholder, Insured Person or Beneficiary aimed at causing the insured event or contributing to its occurrence, except for acts committed in a state of necessary defense or extreme necessity;

2) acts of the Policyholder, Insured Person or Beneficiary recognized as intentional criminal offences or administrative offences that are causally related to the insured event.

14.5. The grounds for the Insurer's refusal to make an insurance payment to the Policyholder shall include:

1) the Policyholder (Insured Person) providing the Insurer with knowingly false information about the subject matter of insurance, the insured risk, the insured event and its consequences, or failing to disclose the required information;

2) the Policyholder, Insured Person and/or Beneficiary being included in the list of persons and organizations involved in the financing of terrorism and extremism, published on the official website of the authorized financial monitoring body of the Republic of Kazakhstan.

In such cases, all monetary transactions involving a person included in the list maintained by the authorized financial monitoring body of the Republic of Kazakhstan shall be frozen until that person is removed from the said list;

3) the Policyholder/Insured Person/Beneficiary failing to provide documents or additional information requested by the Insurer for the purpose of conducting proper due diligence in accordance with the legislation on anti-money laundering, counter-terrorist financing and counter-proliferation financing (AML/CFT/FPWMD);

4) there being grounds to believe that a transaction involving money and/or other property is being carried out for the purpose of money laundering, terrorist financing or the financing of the proliferation of weapons of mass destruction (ML/TF/PF);

5) the Policyholder (Insured Person) obstructing the Insurer's investigation into the circumstances of the insured event or the determination of the amount of loss incurred as a result thereof;

6) the Policyholder (Insured Person) violating the provisions of these Insurance Rules or the Insurance Contract;

7) other cases provided for in these Insurance Rules;

8) the Insured Person (or their heirs) failing to submit an insurance claim and the documents required for the insurance payment within thirty (30) calendar days after arriving in their country of permanent residence;

9) failure to notify the Service Company or the Insurer of the occurrence of an insured event in accordance with the procedure and within the time limits specified in the Insurance Contract, unless the Policyholder (Insured Person) provides documentary evidence of valid reasons for the late notification.

14.6. The release of the Insurer from liability towards the Policyholder on the grounds specified in Clauses 14.4 and 14.5 of this Article shall also release the Insurer from the obligation to make an insurance payment to the Insured Person or Beneficiary.

14.7. Upon the occurrence of an insured event, the Insurer shall make an insurance payment in accordance with the terms of the Insurance Contract.

14.8. The insurance payment shall be made by:

1) the Insurer paying invoices submitted by the Service Company for reimbursement of the costs of providing services stipulated in the Insurance Contract (insurance program);

2) reimbursing the expenses incurred by the Policyholder (Insured Person) in the cases provided for in these Insurance Rules or the Insurance Contract, on the basis of documents confirming

such expenses.

14.9. The total amount of insurance payments for the consequences of one or more insured events occurring during the Insured Person's stay abroad within the term of the Insurance Contract shall not exceed the sum insured specified in the Insurance Contract.

14.10. The insurance payment shall be made in the currency specified in the invoice submitted by the Service Company. Where expenses incurred independently by the Policyholder (Insured Person) are reimbursed, payment shall be made in tenge at the official exchange rate of the foreign currency established by the National Bank of the Republic of Kazakhstan on the date of the insured event.

14.11. To receive an insurance payment, the Policyholder (Insured Person) shall submit a written claim for insurance payment within thirty (30) calendar days after returning to their country of permanent residence.

14.12. The payment period for medical services provided to the Insured Person by a medical facility or the Service Company, as well as for other additional expenses, shall be determined by agreement between the Insurer and the medical facility or the Service Company.

Article 15. TRANSFER TO THE INSURER OF THE POLICYHOLDER'S RIGHTS TO RECOVER LOSSES (SUBROGATION)

15.1. Upon making an insurance payment, the Insurer shall, to the extent of the amount paid, acquire the right of claim that the Policyholder (Insured Person) has against the person responsible for the losses indemnified under the Insurance Contract.

15.2. Upon receiving the insurance payment, the Policyholder (Insured Person) shall transfer to the Insurer all documents and evidence in their possession and provide all information necessary for the Insurer to exercise the right of claim transferred to it.

Article 16. INSURANCE CONTRACT TERMINATION TERMS

16.1. The Insurance Contract shall terminate in the following cases:

1) upon expiry of the term of the Insurance Contract;

2) when the Insurer has made insurance payment(s) in the amount of the sum insured.

16.2. In addition to the grounds for termination of the Insurance Contract specified in this Article, the Insurance Contract shall terminate early in the following cases:

1) the subject matter of insurance ceases to exist;

2) the possibility of an insured event occurring ceases to exist and the insured risk is no longer present due to circumstances other than an insured event;

3) a court decision on the compulsory liquidation (compulsory termination of activities) of the Insurer enters into legal force;

4) changes are made to the terms and information included in the insurance policy issued by the Insurer in accordance with the procedure prescribed by the legislative acts of the Republic of Kazakhstan;

5) in the cases provided for by the Law of the Republic of Kazakhstan "On Insurance Activities".

In the above cases, the Insurance Contract shall be deemed terminated from the moment the circumstance constituting grounds for termination arises. The interested Party shall immediately notify the other Party thereof, enclosing supporting documents.

16.3. In the event of early termination of the Insurance Contract on the grounds specified in Clause 16.2 of these Insurance Rules, when refunding the insurance premium to the Policyholder, the Insurer shall be entitled to retain the portion of the insurance premium proportionate to the period during which the insurance was in force, less the Insurer's administrative expenses in the amount of 25% of the insurance premium, unless otherwise provided for in the Insurance Contract.

16.4. If an individual Policyholder withdraws from the Insurance Contract within fourteen (14) calendar days from the date of its conclusion, the Insurer shall refund the insurance premium (insurance instalments) received from the individual Policyholder, less the portion of the insurance premium (insurance instalments) proportionate to the period during which the insurance was in force and the costs associated with termination of the Insurance Contract, which shall not exceed 10% of the insurance premium (insurance instalments) received.

16.5. If the Policyholder withdraws from the Insurance Contract for reasons other than those specified in Clauses 16.2 and 16.4 of these Insurance Rules, the insurance premium or insurance instalments paid to the Insurer shall not be refundable.

16.6. In the event of early termination of the Insurance Contract on the grounds specified in subparagraph 4) of Clause 16.2 of these Insurance Rules and the conclusion of a new Insurance Policy, the Insurer shall be entitled to retain the portion of the insurance premium proportionate to the period during which the insurance was in force. The Insurer shall offset the portion of the insurance premium attributable to the unused insurance period against payment of the corresponding portion of the insurance premium under the new Insurance Policy.

16.7. The Insurance Contract shall also be deemed terminated in the event of unilateral refusal by either Party to perform the Contract due to a material breach of the Insurance Contract by the other Party. The Party initiating termination of the Insurance Contract shall notify the other Party of the intended termination at least thirty (30) calendar days before the proposed termination date.

16.8. Where early termination of the Insurance Contract is caused by the Insurer's failure to fulfil its obligations under the Contract, the Insurer shall refund the insurance premium or insurance instalments paid by the Policyholder in full.

16.9. In the event of early termination of the Insurance Contract on any grounds, if an insurance payment has been made under the Insurance Contract in any amount, the insurance premium and/or any part thereof shall not be refundable.

16.10. If the Policyholder withdraws from the Insurance Contract without paying the insurance premium, the Policyholder shall pay the full insurance premium to the Insurer within one (1) business day from the date of withdrawal from the Insurance Contract and shall also pay a penalty for late payment of the premium at the rate of 0.1% of the insurance premium payable for each day of delay.

16.11. If an insurance instalment is paid late where the insurance premium is payable in instalments, insurance coverage under the Insurance Contract shall be suspended from the day following the due date of the overdue instalment. If an insured event occurs during the suspension period, the Insurer shall be entitled to refuse to make an insurance payment. Insurance coverage shall resume upon payment of the relevant instalment in accordance with the procedure established by the Insurance Contract.

16.12. If sanctions and/or restrictions imposed by OFAC, the European Union or the United Kingdom are applied in respect of the Policyholder, Insured Person or Beneficiary, or their affiliates, officers, employees, beneficial owners, consultants, representatives, partners or counterparties, the Insurer shall be entitled to terminate the Insurance Contract early and unilaterally by giving written notice to the Policyholder. The Insurance Contract shall be deemed terminated from the moment the Insurer sends the notice to the Policyholder by email or post to the address specified in the Insurance Contract.

Upon termination of the Insurance Contract pursuant to this Clause, the Insurer shall be entitled to retain the portion of the insurance premium proportionate to the period during which the insurance was in force, less administrative expenses amounting to 25% of the insurance premium. In the event of unilateral termination of the Contract pursuant to this Clause and refusal to make an insurance payment due to sanctions and restrictions, the Insurer shall not pay any penalty or compensate the Policyholder/Insured Person/Beneficiary for any losses.

Article 17. CONSEQUENCES OF AN INCREASE IN INSURANCE RISK DURING THE TERM OF THE INSURANCE CONTRACT

17.1. During the term of the Insurance Contract, the Policyholder (Insured Person) shall immediately notify the Insurer in writing of any material changes that become known to them in the circumstances disclosed to the Insurer upon conclusion of the Insurance Contract, if such changes may significantly increase the insured risk.

17.2. The following changes shall in any event be deemed material:

1) a change in the purpose of the trip;

2) a change in the territory of insurance or the purpose of travel;

3) the identification of any disease or condition in the Insured Person that is included in the list of exclusions from insured events provided for in these Insurance Rules.

17.3. Upon being notified of circumstances that entail an increase in the insured risk, the Insurer shall be entitled to require amendments to the terms of the Insurance Contract and payment of an additional insurance premium proportionate to the increase in the insured risk.

17.4. If the Policyholder or Insured Person objects to amendments to the terms of the Insurance Contract or payment of an additional insurance premium, the Insurer shall be entitled to demand termination of the Insurance Contract.

17.5. If the Policyholder or Insured Person fails to fulfil the obligation specified in Clause 17.1 of this Article, the Insurer shall be entitled to demand termination of the Insurance Contract and compensation for losses caused by such termination.

17.6. The Insurer shall not be entitled to demand termination of the Insurance Contract if the circumstances giving rise to an increase in the insured risk have ceased to exist.

Article 18. ADDITIONAL PROVISIONS

18.1. Disputes arising under the Insurance Contract between the Insurer and the Policyholder (Beneficiary) shall be resolved directly by the Parties through negotiations.

18.2. If no agreement is reached through negotiations, the Insurer shall notify the Policyholder (Insured Person, Beneficiary) of their right to apply to the Insurance Ombudsman (Financial Ombudsman as of 1 January 2027) to resolve the dispute, subject to the specific requirements of the legislation of the Republic of Kazakhstan. A Policyholder (Insured Person, Beneficiary) who is an individual and/or a small business entity shall submit a written application directly to the Insurance Ombudsman (Financial Ombudsman as of 1 January 2027) for dispute resolution, accompanied by supporting documents, including through the Insurance Ombudsman's (Financial Ombudsman's as of 1 January 2027) website: info@fomb.kz, tel.: +7 (727) 382-41-74, +7 (727) 265-54-70, +7-771-990-58-27. Other legal entities (medium-sized and large business entities), if no agreement is reached through negotiations, shall refer the dispute to the courts in accordance with the applicable legislation of the Republic of Kazakhstan without applying to the Insurance Ombudsman (Financial Ombudsman as of 1 January 2027).

18.3. Disputes not resolved by the Parties through negotiations shall be referred to the courts of Almaty. Where a legal entity is a party to the Insurance Contract, the dispute shall be considered by the Specialized Interdistrict Economic Court of Almaty. Where an individual is a party to the Insurance Contract, the dispute shall be considered by District Court No. 2 of the Almaly District of Almaty, at the Insurer's location.

18.4. These Insurance Rules have been drawn up in Kazakh and Russian.

18.5. All notices under the Insurance Contract shall be made in writing. The Insurer shall be entitled to send notices by email to the Policyholder's email address and/or through the Policyholder's personal account, or by SMS to the Policyholder's mobile phone number.

18.6. By entering into the Insurance Contract, the Policyholder, Insured Person and Beneficiary confirm that they have an insurable interest in preventing risks and avoiding the occurrence of an insured event.

18.7. The Policyholder, Insured Person and Beneficiary may not transfer their rights and obligations under the Insurance Contract to third parties without the Insurer's written consent.

18.8. Upon conclusion of the Insurance Contract, the Parties shall be entitled to amend, exclude and/or supplement the provisions of these Insurance Rules by expressly providing for such changes in the Insurance Contract, the provisions of which shall prevail in governing the relations between the Parties.