Main definitions used in the wording

Unless otherwise defined in Conditions all terms used herein shall have the following meanings assigned to them:

Insurer – is the party to an insurance agreement, which is a local legal entity with a relevant license to carry out insurance activities and legally liable to pay an indemnity in the case of an insurance event indicated in the Insurance Agreement takes place;

Policyholder/insured – a party of the insurance contract who pays the insurance premium and have an insurable interest in the object of insurance;

Insured persons – a person (under age 75) whose interests are protected by an insurance policy (except persons whose ability to act is restricted by the court or has limited or no capacity to act);

Assistance Company – A company that organizes providing of medical and other assistance to the insureds outside the borders of Azerbaijan Republic, under the agreement concluded with an Insurer;

Actuary – a specialist who analyses statistics and uses them to calculate insurance risks, premiums, and premium reserves while complying with legislation;

Beneficiary – a person or entity entitled to receive the claim amount/ compensation and other benefits, if any;

Insurance contract – a contract, specifying terms and conditions, under which the Insurer accepts the named insurance risks and agrees to compensate the policyholder if an insured event occurs in return of insurance premium provided by the policyholder;

Insurance policy – a document that proves the existence of an insurance contract, issued by the Insurer to the Insured and/or the Policyholder;

Insurance card – a plastic card containing the data on the İnsured party's name, surname, patronymic, date of birth, insurance card number, insurance program/package, effective period for insurance coverage, contact details of the Insurer, etc.;

Insurance coverage – insurance benefits or medical services provided by the Insurer under the insured's medical insurance program;

Insurance object – any property interest of the Policyholder or Insured not contradicting the law;

Subject matter insured – a natural person to whom insured's proprietary interest belongs to according to an insurance agreement;

Insurable interest – the possibility of the Insured to incur a financial loss in case of an insurance event is the basis for Insured to insure the object of insurance;

Insurance risk or risk – the probability of occurrence of an event or circumstance which might cause losses or damage to the object of insurance, as well as the liability undertaken by the Insurer against such probability;

Insurance event – an event or circumstance occurring during an insurance period and serving as a ground to indemnify the insured, insured person or other beneficiary in accordance with legislation or an insurance agreement;

Insurance claim – a request made by the Insured, Policyholder or beneficiary to the Insurer to fullfil its duties in accord with the legislation and insurance agreement in case of occurrence of an insurance event;

Insurance period – a period during which insurance risks are considered insured;

Insurance amount – maximum extent of an Insurer's liability in respect of the insured risks indicated in the monetary amount as determined in the legislation or an insurance agreement;

Insurance premium – the monetary amount payable by the Insured to the Insurer for acceptance or distribution of the risks in accordance with legislation and as determined in the Insurance Agreement;

Unconditional deductible – part of the loss amount (that occurred as a result of an insurance event) that is not covered by the insurance policy and which an Insured is liable for;

Unconditional waiting period – a period not covered by an insurance contract;

Insurance payment – financial compensation disbursed by the Insurer in line with legislation and Insurance Agreement in case if an Insurance event takes place;

Area of insurance – certain territorial boundaries where the insurance object is deemed to be insured;

Significant circumstances – all circumstances affecting the decision of the insurer to void the agreement or agree to conclude it only after changing the context of an agreement;

Special definitions

Medical institution – legal persons/entity with relevant special permits providing the Insured with medical assistance and other services specified in the contract/agreement and receiving service fee from the Insurer for the services provided;

Treatment – Medical measures bringing the Policyholder or the Insured to the same physiological condition prior to the occurrence of an insurance event or improving its condition;

Physician – a practicing person holding a legal license and treating patients within his/her qualifications;

Chronic disease or condition – any disease or injury having at least one of the following symptoms:

- ✓ continuance for a long time;
- ✓ disease recurrence;
- ✓ or disease recurrence is probable (disease symptoms periodically reoccur);
- ✓ disease permanency (exists all the time, although disease symptoms decrease or increase periodically);
- ✓ rehabilitation is needed to eliminate the disease;
- ✓ patient needs long term treatment, diagnostic test, medical examination, and medical control

An accident – bodily injury or any health disorders as a result of a sudden and unexpected circumstance requiring immediate emergency intervention independent of the will of the insured and occurring during an insurance period;

Family member of the insured party – insured's spouse, children (under 18 or students under parental care – below the age of 21);

Administrative costs – costs/expenses incurred by the insurer for business administration

CHAPTER 1. GENERAL PROVISIONS

Article 1. Class of insurance

1.1. Below classes related to personal insurances in accordance with an insurance object:
1.1.1. Payment of insurance compensation in full or partial regarding the medical services provided to the insured under his/her medical insurance program.

Article 2. Subject matter of insurance

2.1. As per current conditions proprietary interests of the natural person is considered to be a subject matter of an insurance.

CHAPTER 2. INSURANCE COVERAGE

Article 3. Insurance risk and insurance event:

3.1. Illnesses or incidents involving the insured and requiring medical examination/treatment or any other cases that are covered under the insurance policy will be considered as an insurance event, unless it contradicts with the insurance conditions/wordings or the insurance period.
3.2. In accordance with the terms and conditions of the insurance policy, the Insurer shall arrange medical services for the insured parties and pay relevant compensations (within the limit of the insurance amount) if the insurance event occurs;
3.3. Medical services to be covered under the insurance policy are determined based on agreement between the Insurer and the Policyholder.

Article 4. Exclusions from Insurance Risks and (or) Limitations in the Insurance Coverage:

4.1 Exclusions are described below:
4.1.1 Emergency state, wars, military conflicts, revolutions, riots, revolts, natural disasters, nuclear explosion, traumatic injuries as a result of radioactive radiation and other cases; chronic and acute radiation disease, etc.;
4.1.2. Hunting, alpinism, soaring, caving, sky diving, underwater sports, winter sports, rugby, polo, martial arts, motorcycling and horse race, water skiing, any port competition or trainings for such competitions as well as any other activities causing a high level hazard for life and health;
4.1.3. Suicide attempt, illegal acts, including, the diseases and damages resulting from intentional self-injury;
4.1.4. Preventive examinations for issuing medical findings (traveling abroad, employment, enrolling for a higher educational establishment, carrying arms and submitting to relevant establishments, etc.);
4.1.5 Substance abuse, alcoholism, drug abuse, examination and treatment of any case arising out of these conditions;
4.1.6. Tuberculosis, all types of systematic diseases (collagen disease, sarcoidosis, mucoviscidosis, etc.); occupational diseases stipulated by the legislation of the Azerbaijan Republic;
4.1.7. Examination and treatment of STDs and venereal diseases (AIDS, acquired immune deficiency infections, mycoplasmas, clamidiosis, ureaplasmosis, cytomegalovirus, herpetic infections etc.);
4.1.8. Dermatological diseases (papilloma, wart, pustules, alopecia, seborrhea, psoriasis, chloasma, vitiligo), and also, examination and treatment of cosmetological defects;
4.1.9. Services of a psychologist, psychotherapist, psychoanalyst, extrasensory perception expert, narcologist and sexual health expert, treatment of mental illnesses and severe nervous breakdowns; epilepsy and complications in consequence thereof;
4.1.10. Congenital and hereditary pathologies, although revealed after insurance coverage date, body deformities and also, treatment of pathological vertebral deformities;
4.1.11. Family planning, examination and treatment of infertility, contraception, artificial prevention of pregnancy, post-artificial insemination prenatal care and birth, sexual dysfunctions and any diseases arising thereout;
4.1.12. Plastic and cosmetological treatment/surgeries, reconstructive surgery; removal of the deviation of nasal septum by surgery;
4. 1.13. Transplantation, implantation, all types of prosthetics and medical equipment, orthopedic surgery and other auxiliary equipment made of artificial materials;
4.1.14. Surgical treatment of visual impairment and correction via special equipment, treatments conducted in connection therewith and for determination of working capacity, myopia, presbyopy, hypermetropia, ametropia and surgical treatment of ocular refraction, such as astigmatism, including laser method; supply of contact lenses and glasses;

4.1.15. Treatment of periodontitis; cosmetic dentistry, also, removal of dental calculus, fluoride varnishing of teeth and tooth bleaching; elimination of orthodontic defects and dental prosthetic rehabilitation;
4.1.16. Cardio-vascular diseases requiring surgical treatment, invasive cardiology; all types of circulatory collapse as well as varicosity of lower limbs;
4.1.17. Any kind of malignant oncological diseases or the cases considered a transition stage to these diseases, oncological blood diseases;
4.1.18. All types of hepatitis and all complications arising thereout;
4.1.19. Diabetes and all complications arising thereout (microangiopathy, retinopathy, etc.);
4.1.20. Examination and treatment in specialized state medical institutions under special circumstances (communicable and infectious diseases, intoxication, burns, etc.);
4.1.21. Examination and treatment of hazardous infections (avian influenza, swine influenza, ebola hemorrhagic fever, yellow fever, etc.);
4.1.22. Obesity, problems associated with excessive weight due to metabolic disorder;
4.1.23. Examination and treatment of irregular menstrual cycles and other dysfunctions for more than 6 (six) months;
4.1.24. Chronic renal and liver insufficiency, extra-corporal treatment methods (plasmapheresis, hemodialysis, hemosorption, ozone therapeutics, ultraviolet blood irradiation);
4.1.25. In-patient treatment for more than 90 days a year during the effective period of the policy; parents remaining in hospital with children during in-patient treatment;
4.1.26. Insurance of newly born infants up to 40 (forty) days;
4.1.27. All kinds of rehabilitation measures, over 10 sessions of physiotherapy, over 10 sessions of massage;
4.1.28. Any treatment or pharmaceuticals prescribed for preventive care; examination of immunological status (immunogram);
4.1.29. Diseases occurring prior to execution of the insurance agreement;
4.1.30. Chronic diseases, except for sequelae;
4.1.31. Medicinal drugs, bioactive nutritional supplements, homeopathic preparations, lacquer, shampoo, and cosmetic goods which are not licensed by the Ministry of Health of the Azerbaijan Republic; immunomodulators; provision of the whole package of pharmaceuticals at once to be used for a period of more than one month (in long-term treatments);
4.1.32. Types of examination and treatment that are considered by the Insurer to be experimental/ alternative based on Azerbaijani practice, examination and treatment methods, examination and treatment by the physicians, such as trichologist, cosmetician, speech therapeutist, geneticist, andrologist, algologist, etc. which are not licensed by the Ministry of Health of the Azerbaijan Republic;
4.1.33. Asking for physicians not employed by contractor clinics, examination and treatment by those physicians without prior agreement with the Insurer as well as any consequences of such treatment and complications; complications arising out of the Insured party's failure to comply with a physician's prescription; extra charged services provided by clinics (differences in medical services (as opposed to the prices provided in the clinic's price list), calling a doctor outside working hours at the request of the insured party, replacement of a physician unreasonably, services by foreign specialists, extra services, charged telephone consultation, recording MRT examination to a disc, etc.);
4.1.34. Repeated costs for the treatment not conducted at the insured party's initiative;
4.1.35. Medical and other services not covered under the insurance policy;
4.2. If the Insured visits the medical institutions not mentioned in the selected program without prior agreement with the Insurer, the Insurer shall have the right to refuse to reimburse the expenses or other medical services connected with the treatment of the Insured party.
4.3. Amendments to the Exclusions from Insurance Risks and (or) Limitations in the Insurance Coverage:
4.3.1. The Insurer can arrange examination and treatment of the illnesses not covered under the insurance policy subject to payment of extra insurance premium by the Insured;
4.3.2. The Insurer may pay for some of the listed medical services at its own initiative (with the consent of the Insured) or upon request by the Insured;

Article 5. Changes in the insurance risks
5.1. During the effective period of the insurance agreement, the Policyholder shall immediately notify the Insurer about the changes in the important (material) facts that can affect the insurance risk significantly, which are known to the insured;
5.2. If the changes in the material facts increase the insurance risk, the Insurer has the right to act as follows;
5.2.1. Change the terms and conditions of the insurance policy;

5.2.2. Require payment of additional insurance premium;
5.2.3. Cancel the insurance agreement effective from the date these changes take place.

Article 6. Insurance area
6.1. Unless otherwise stated in the insurance policy, insurance coverage is valid in the territory of the Azerbaijan Republic;
6.2. If insurance territory has been specified in the insurance policy, insurance coverage is provided for the insurance events occurring in that territory only;
6.3. Insurance area may be extended subject to prior notification given to the Insurer thereof and obtainment of its written approval. In this case, the Insurer has the right to demand additional insurance premium.

CHAPTER 3. INSURANCE CONTRACT/AGREEMENT

Article 7. Conclusion of insurance contract/agreement
7.1. The Policyholder shall submit the following information to the Insurer upon execution of the Insurance Contract:
7.1.1. Address and telephone numbers;
7.1.2. Name of the Policyholder (if legal person), name, surname, patronymic name (if natural person/individual);
7.1.3. Surname, name and patronymic name of the insured;
7.1.4. Date of birth of the insured;
7.1.5. The facts, which may be important in calculation of the insurance premium and determination of the degree of risk known to the Policyholder;
7.2. Conclusion of the insurance contract/agreement is proved by delivery of insurance policy together with insurance wordings to the Policyholder.
7.3. Unless otherwise stated in the insurance contract/agreement, the insurance contract/agreement shall become effective at 00:00 and become ineffective at 23:59 on the dates specified in the policy;
7.4. The insurance coverage applies to the insurance events taking place during the effective period of the insurance agreement only;
7.5. The Policyholder and the Insurer may also agree on other terms and conditions, unless they contradict the legislation.

Article 8. Parties to the Insurance Agreement

8.1. Insurer
8.1.1. According to the insurance wording, "PASHA Insurance" OJSC is deemed to be an insurer.

8.2. Policyholder
8.2.1. Natural or legal entity who pays the insurance premium and have an insurable interest in the object of insurance;

8.3. Insured
8.3.1. Subject to the insurance contract/ agreement, the insured is the person with insured property interests (except persons whose ability to act is restricted by the court or has limited or no capacity to act);

8.4. Beneficiary
8.4.1. The insurance contract/agreement may be concluded to the benefit of any other person – a beneficiary – who is interested in protecting the insurance object;
8.4.2. The beneficiary's name shall be specified in the insurance contract;
8.4.3. Conclusion of the insurance contract to the benefit of a beneficiary shall not free the Insured of the duties and obligations specified thereunder;
8.4.4. All terms and conditions attributed to the policyholder under the contract, apply to the beneficiary, as well;

Article 9. Additions and amendments to the insurance agreement
9.1. The Policyholder and the Insurer may agree to make changes/additions to certain policy terms and conditions during the effective period of the contract.

Article 10. Termination of the insurance agreement

10.1. The insurance contract is terminated under the following cases:
10.1.1. Upon expiration;
10.1.2. When the insurer has completely fulfilled its obligations under the contract;
10.1.3. If the insured fails to pays the insurance premium in the time established by the agreement;
10.1.4. Upon liquidation of the Insurer subject to the legislative acts of the Azerbaijan Republic;
10.1.5. If there is a court decision on invalidity of the insurance contract;
10.1.6. If an insurance interest no longer exists;
10.1.7. If the subject matter of insurance no longer exists;
10.1.8. Upon the policyholder's failure to conform the contractual obligations;
10.1.9. In any other cases stipulated under legislation of the Azerbaijan Republic;
10.2 The insurance agreement may be terminated early upon request of either the Policyholder or the Insurer. Except for the cases stipulated by law, the parties must notify each other about it in a written form at least 30 (thirty) days in advance.

Article 11. Consequences of premature insurance contract termination

11.1. When the Insurance Contract (in case of group insurance with regard to subject matter of insurance) is terminated prematurely at the request of Insured, the Insurer shall reimburse insurance premium for the outstanding period of the Agreement deducting the administration costs under the insurance contract (in case of group insurance with regard to subject matter of insurance proportion of an insurance premium). If such request is related to failure of Insurer to follow its contractual obligations, the Insurer shall fully reimburse the insurance premium to the Insured (in case of group insurance paid insurance premiums in respect of subject matter of insurance);
11.2. In the event if the Insurance Agreement (in case of group insurance with regard to subject matter of insurance) is terminated prematurely at request of the Insurer, the Insurer fully reimburses the insurance premium (in case of group insurance paid insurance premiums in respect of subject matter of insurance) to the Insured. If such request is related to failure of Insured to follow its contractual obligations, the Insurer shall reimburse insurance premium (in case of group insurance proportion to the insurance premiums in respect of subject matter of insurance) for the outstanding period of the Agreement deducting administration costs of the insurance agreement;
11.3. If the Insurance Agreement (in case of group insurance with regard to subject matter of insurance) is terminated prematurely, if any indemnity equal to or exceeding the Insurance premium (in case of group insurance paid insurance premiums in respect of subject matter of insurance) are paid by the Insurer to the Insured prior to the termination date, the Insurance premium is not reimbursed to the Insured;
11.4. If the Insurance Agreement (in case of group insurance with regard to subject matter of insurance) is terminated prematurely, if any indemnity less than the Insurance premium are paid by the Insurer to the Insured prior to the termination date, the insurance premium equal to the difference between the Insurance Premium and the Indemnity amount is reimbursed to the Insured according to Articles 12.1 and 12.2 hereof;
11.5. If the Insurance Agreement is considered terminated under a court decision as determined in the Article 12.2, the Insurer shall reimburse to the Insured's authorized legitimate representative the insurance premiums for the outstanding period of the Agreement (in case of group insurance with regard to subject matter of insurance) deducting administration costs of the insurance agreement according to Articles 12.3 and 12.4 hereof.

Article 12. Rights and Duties of the Parties:

12.1. The Policyholder's rights:
12.1.1. Request provision of the insured persons with the medical services at the relevant medical institutions in accordance with terms and conditions under the insurance policy/ program;
12.1.2. Receive a duplicate, if insurance certificate is lost;
12.1.3. Terminate the insurance contract before its expiration by submitting a written notice to the Insurer 30 days in advance;
12.1.4. Other rights stipulated by existing legislation.

12.2. The Policyholder's duties:
12.2.1. Pay the insurance premium based on timeline/conditions under the policy;

12.2.2. Inform the Insurer about all material facts before/while concluding the insurance contract which are known to the Policyholder, required by the Insurer in a written form, and/or capable of impacting the decision of the Insurer with accepting/rejecting the risk and terms and conditions;
12.2.3. Inform the Insurer about other insurance contracts;
12.2.4. Inform the Insurer about the changes in the list of insured persons during the effective period of the insurance contract;
12.2.5. If an insurance event occurs, notify the Insurer about it within the period specified in the insurance contract;
12.2.6. Ensure storage and confidentiality of the medical insurance cards and all documents under the contract, except for provision of data to state authorities and other organizations in connection with the necessity arising in the course of the Insurer's work process;
12.2.7 Other duties stipulated by existing legislation.

12.3. The Insurer's rights:
12.3.1. Request the Policyholder to submit necessary information/documents in order to conclude insurance contract;
12.3.2. Review the accuracy of the data provided by the Policyholder; upon conclusion of insurance contract, request the Policyholder to inform about all material facts which are known to the Policyholder, required by the Insurer in a written form, and/or capable of impacting the decision of the Insurer with accepting/rejecting the risk and terms and conditions;
12.3.3. Monitor adhering the terms and condition by the Insured; terminate the contract ab initio or reject the claim payment if contractual terms are not adhered by the Policyholder (Insured) or pre-contractual information duty is breached by the Policyholder (Insured);
12.3.4. Bring subrogation claim against the third party who is liable for the damage/loss (unless the damage is caused by the insured);
12.3.5. Be freed from claim payment when the Insured hands the insurance card to a third party or in any other case mentioned in the policy;
12.3.6. Do not accept the Insured party's request on replacement of the doctor or medical institution if sufficient reasons are not provided;
12.3.7. Other rights stipulated in the legislation.

12.4. The Insurer's duties:
12.4.1. Familiarize the Policyholder with medical insurance wording;
12.4.2. When the insurance event occurs, arrange provision of the insured with services according to the terms and conditions written in the insurance contract;
12.4.3. When the insurance event occurs, pay the expenses related with the medical assistance and other services provided to the Insured on time and in agreed manner;
12.4.4. Review the scope, duration, and quality of medical service in accordance with the terms and conditions of the contract;
12.4.5. Assure confidentiality of the data about the health, medical indications, etc. of the Insured and do not provide the Policyholder or any third party with any information unless the Insured provides an explicit written permission therefor;
12.4.6. Other duties stipulated in the legislation.

12.5. Rights of the Insured:
12.5.1. Request provision of the medical services in accordance with medical insurance program/policy;
12.5.2. Notify the Insurer, if the medical assistance and other services defined in the contract are not provided or provided incomplete or poor;
12.5.3. Select any one of the medical institutions specified in the insurance contract/program for provision of medical service;
12.5.4. Select the doctor from the list of involved doctors for provision of medical service;
12.5.5. Ask to the Assistance firm (whose phone number is specified on the insurance card) or the Insurer in order to obtain information about the medical program and benefit from medical assistance or services;
12.5.6. Notify the Assistance firm or the Insurer about conflicts/disputes in provision of medical services under the program;
12.5.7. Other rights stipulated in the legislation.

12.6. Duties of the Insured:

12.6.1. Comply with all instructions of the doctor during the treatment period in any medical institution;
12.6.2. Assure safekeeping of the medical insurance card and the contract documents and not giving them to a third party;
12.6.3. Inform the Insurer immediately when an insurance event occurs;
12.6.4. Provide all necessary/required information to the Insurer's employee;
12.6.5. Notify the Policyholder immediately if the insurance card or other important documents are lost. Lost document is considered ineffective and cannot be considered as basis for provision of medical services throughout the duration of the insurance contract, in which case the Insurer will provide a new insurance card for free of charge;
12.6.6. Do not hand insurance documents to other persons for benefiting from the medical services under the insurance contract. If the fact that insurance card has been handed to any other person for the purpose mentioned above, the Insurer retains the right to terminate the insurance contract against the insured;
12.6.7. Other duties stipulated in the legislation.

Article 13. Contractual information duty

13.1. Before/while concluding the insurance contract, the Policyholder is obliged to keep the Insurer informed about all material facts known to the Policyholder, required by the Insurer in a written form, and/or capable of impacting the decision of the Insurer with accepting/rejecting the risk and terms and conditions. If inaccurate data, which is material, is provided in the application, the Insurer may avoid the contract.
13.2. If inaccuracy of the data was known to the Insurer or the provision of inaccurate information by the Policyholder was neither deliberate nor reckless, insurance contract will not be avoided by the insurer. The Insurer may cancel the contract after notice about this information is given.
13.3. If the Insurer was aware of the undisclosed information or the provision of inaccurate information by the Policyholder was neither deliberate nor reckless, termination of the contract under these grounds on this account is unacceptable.
13.4. In case the Insurer cancels insurance contract after the occurrence of an insurance event, the insurer is not freed from the claim payment, unless the breach of contractual information duty has impact on the insurance event and performance of the insurer under the terms and conditions.

CHAPTER 4. INSURANCE AMOUNT AND INSURANCE PREMIUM

Article 14. Insurance amount
14.1. The insurance amount is determined in accordance with the medical insurance program selected by the Policyholder under the insurance contract;
14.2. The insurance amount for each insured for an insurance period of less than one year is equal to the insurance amount for whole year;
14.3. According to the agreement of the Policyholder with the Insurer, the former have the right to extend the list of services provided in the medical program by increasing the insurance amount or making an amendment to the program and paying additional insurance premium during the effective period of the insurance contract;
14.4. If the value of medical services exceeds the insurance amount, service may be provided in return of the extra payment by the Insured to the Insurer. In that case, the Insurer and the Insured sign an amendment and the policyholder pays an additional amount to the Insurer as per the medical institution's price list.

Article 15. Insurance premium
15.1. The insurance premium is calculated based on the factors which affect insurance risk (effective period of the insurance agreement, number of the insureds, age and gender of the insureds, type of activity, medical services selected by the Policyholder, number of medical institutions, list of exceptions, etc.);
15.2. Insurance premium is paid at once or, if agreed, it can be paid according to the installments established by the Insurer;
15.3. The day on which insurance premium is paid is considered the day on which the amount is received at the Insurer's bank or cash account;

15.4. Unless otherwise stated in the agreement, the insurance contract is effective following the day on which first part or full amount of the insurance premium is paid, however, no later than commencement date of the insurance period specified on the policy;
15.5. If the insurance premium or its subsequent part is not paid within the specified period or the amount paid is less that the amount specified in the insurance contract/ installment plan, the Insurer is freed from the liability for claims starting from 00:00hrs on the day following the date specified in the insurance agreement as the payment day for the insurance amount or subsequent part thereof;
15.5.1. If the insurance premium or its part is not paid on time, the Insurer may require premium payment within period of maximum 15 (fifteen) days in accordance with legislation.
15.5.2. In any case, the insurance premium or its agreed part must be paid no later than 1 month following the conclusion of the insurance contract;
15.6. If the Policyholder fails to pay the insurance premium or its subsequent part within the period specified in the insurance contract/ installment plan, the Insurer may terminate the insurance contract or unilaterally reject to perform its duties under the contract;

Article 16. Deductible and waiting period
16.1. Conditional and unconditional deductibles as well as waiting period may be stated in the insurance contracts.
16.2. Deductible is the part of the loss amount (that occurred as a result of an insurance event) that is not covered by the insurance policy and which an Insured is liable for. The deductible should be deducted from the amount of the loss according to the insurance contract/policy.
16.3. If conditional deductible is applied, deductible amount is not accounted/subtracted when loss amount (that occurred as a result of an insurance event) exceeds deductible amount.
16.4. If unconditional deductible is applied, that amount shall be accounted in any case.
16.5. If a waiting period is applied in the insurance contract/policy, Policyholder will be liable for the reimbursement of the losses that arose during waiting period (that occurred as a result of an insurance event).
16.6. If a conditional waiting period is applied, insurer will be liable for the whole loss if duration of the treatment is equal to or more than the conditional waiting period mentioned in the contract/policy.

CHAPTER 5. INSURANCE EVENT. PROVISION OF MEDICAL SERVICES

Article 17. The Policyholder's duties in case of an insurance event and supervision by the Insurer
17.1. In case of occurrence of an insurance event, the Insured should inform the representative of the Insurer (or the Assistance company) via telephone or any other means of communication within the shortest period of time possible prior to visiting any medical institution specified in Voluntary Medical Insurance Program;
17.2. Irrespective of the policy cover, the Policyholder is obliged to take all reasonable and required measures in order to reduce any occurred loss, injury, and liability and prevent such losses in future;
17.3. Loss, injury, and liability occurring directly or indirectly as a result of the Insured's failure to take such measures are not covered under the policy;
17.4. The Policyholder should comply with all instructions received from the Insurer for taking such measures;
17.5. The Insurer may not pay overhead in the amount of the loss occurred as a result of the failure to take such measures, such as, preventing the loss or reducing the scale of the loss;
17.6. The Insurer shall supervise all acts of the Insured in connection with an insurance event and the consequences thereof and be able to adopt a decision on all matters capable of affecting the insurance compensation;
17.7. The Policyholder should assist the Insurer as far as practicable. The Insurer shall have the right to represent and defend the rights of the Policyholder at its own expense in all official and unofficial surveys associated with the insurance event. The Policyholder shall not perform any act directed to acknowledgement of its liability, sign an agreement or make a promise without preliminary approval of the Insurer.

Article 18. Validation of an insurance event
18.1. The burden of proving the loss remains with the Policyholder. The Policyholder must give full particulars of the loss, establish amount of the loss, and clarify that the fact that the loss was caused by the operation of an insured peril.
18.2. The documents required for provision of insurance compensation are as follows:

18.2.1. The relevant document provided by state authority with respect to the insurance event, if any state authority needs to be notified in accordance with the legislation;
18.2.2. Identification card;
18.2.3. Other necessary documents confirming the occurrence of an insurance event;
18.3. Unless otherwise stated in the contract/policy, these are the collection of the least required documents. If necessary, the Insurer can require the Policyholder to submit other important documents defining the causes and evidence of the occurrence of an insurance event and level of the damage.

CHAPTER 6. INSURANCE COMPENSATION

Article 19. Insurance compensation

19.1. According to the insurance contract, Insurer must make payment for provided services to the medical institution.
19.2. If the Insured has selected a medical institution that is not specified in the medical insurance program, with consent of the insurer, the Insurer should pay the insurance compensation directly to the Insured. In this case, the Insured must provide the following documents:
19.2.1. The application form filled by the Insured (to be submitted to the Insurer no later than one month following the provision of medical services);
19.2.2. Original version of the paid bill;
19.2.3. List and prices of provided services;
19.2.4. Receipt/invoice;
19.2.5. Referral;
19.2.6. Extract from in-patient of outpatient clinical record, etc.
19.3. The Insurer shall pay the insurance compensation within 7 (seven) working days after the Insured has submitted the last document specified in paragraph 19.2 of these wording or refuse to pay compensation by stating the reason.
19.4. The amount of compensation shall be determined by taking into consideration the average price of analogous services in the medical institutions specified in the list attached to the insurance contract;
19.5. All exemptions specified in the insurance program will be deducted from the amount of payment during the calculation of insurance compensation;
19.6. In accordance with the Voluntary Medical Insurance program any diagnostic or curative measures will be carried out as prescribed by physician only;
19.7. The Policyholder shall refund to the Insurer the amount spent on the services provided to the person, illegally using the Policyholder's insurance card due to the fault of the Policyholder or the Insured;
19.8. If the Insured is late for an appointment with a doctor or is not at the specified address upon call of medical care team or medical specialists and fails to notify the representative of an insurance company about it in advance, the Insured must pay all these costs directly to the medical institution.

Article 20. Grounds for refusal to pay insurance compensation

20.1. The insurer refuses to pay insurance compensation in the following cases:
20.1.1. If the Insurer cannot identify insurance event as a result of not adhering to the provisions of the article 18.1 of these Conditions by the Insured.
20.1.2. Intentional act or omission by the Policyholder that causes damage to the victim, as well as, commitment of crime caused directly by the intentional act of policyholder; Cases stated in legislation of the Azerbaijan Republic that free the doer from such liability are excluded;
20.1.3. Occurrence of the event as a result of the military operations or actions related to military operations, if military risks are not covered;
20.1.4. Intentional failure to take required and possible measures by the Policyholder to prevent the caused damage or reduce its extend. In these circumstances, insurance compensation may be reduced based on the loss which has been extended as a result of intentional failure to take required and possible measures by the Policyholder;
20.1.5. In view of the paragraph 21.2 of this wording, full or partial deprivation of the Insurer to assess insurance risk as well as determine the causes of an insurance event and/or scope of loss/damage as a result of intentionally given inaccurate/false information by the Policyholder to the Insurer with regard to the subject matter of insurance, the Insured person, and/or an insurance event;
20.1.6. When an event is not considered an insurance event according to the insurance contract;

20.1.7. In case of occurrence of an insurance event, if the relevant part of the insurance premium is unpaid for more than 15 days after its due date (stated in the contract/installment plan) or 3 days after date mentioned according to the paragraph 15.5.1.
20.2. If inaccuracy of the information stipulated in the paragraph 12.3 of this wording is known to the Insurer before/while entering into the insurance contract or the Policyholder is not at fault with respect to provision of incorrect information, as well as, in the event that insurance agreement is concluded despite absence of response from the Policyholder to requested information, the Insurer may not be freed from payment of an insurance compensation on the grounds of provision of incorrect information or not provision of required data to Insurer;
20.3. Intentional act or omission by the Beneficiary (who is neither Policyholder not the Insured) that causes damage to the victim, as well as, commitment of crime caused directly by the intentional act of Beneficiary (who is neither Policyholder not the Insured); Cases stated in legislation of the Azerbaijan Republic that free the doer from such liability are excluded;

Article 21. Right of subrogation
21.1. Subrogation is the right of the Insurer, once he have made insurance payment due, to exercise any rights or remedies of the insured arising out of the insured event/loss or damage to recover their outlay from a culpable party.
21.2. Insurer obtains beneficiary's right to seek reimbursement from the culpable party within the limit of such payment made according to the subrogation process.
21.3. Having received insurance payment, Beneficiary shall provide the Insurer with all necessary documents he has, enabling the Insurer to exercise its subrogation rights.
21.4. In case if the beneficiary fails to provide the Insurer with necessary documents or refuses to transfer his rights to bring a claim against culpable party to seek reimbursement, the Insurer is exempted from the payment in the extend of the amount recoverable from the person responsible for the loss in the course of subrogation process.
21.5. Insurer can exercise his subrogation rights against culpable party and (or) against the Insurer who insures this person’s liability related to such risks, also against other person liable for the loss before the beneficiary or the insured.

Article 22. Responsibility of parties
22.1. Parties bear responsibility as set forth in legislation for failure to perform or failure to properly perform terms and conditions herein.

Article 23. Confidentiality of work secrets
23.1. The Insurer is responsible in line with legislation for material and moral damage incurred by the insured for the failure of the insurer to maintain confidentiality of the information about the insured received in the course of business/work process.

Article 24. Dispute resolution
24.1. All disputes arising out of or in connection with the Insurance Contract should be resolved by reaching an agreement on the basis of claims, however, if the parties cannot reach an agreement, disputes should be resolved through submitting to the court in line with legislation of Azerbaijan Republic.

Article 25. Provisions and specific terms
25.1. To amend or change any provision of insurance condition, clauses may be added to these conditions.
25.2. Special provisions/terms may be set out in the insurance contract that are not contrary to the current law and conditions. If the insured does not adhere these special provisions, insurer may refuse to pay insurance payment.