GENERAL TERMS OF PERSONAL ACCIDENT

APPLICABLE FOR ALL ANNEXES

ARTICLE 1. INSURANCE POLICY:

The group insurance policy, the registrations, the amendments, the application form of the Policyholder, the attached documents and the endorsements, if any, consist of the full insurance policy between the contributing parties.

No variance in the insurance policy is valid, unless it receives approval from the Company and is attached to it.

The insurance intermediary does not have approval or authorization to modify or alter or quit any term, provision or limitation of this policy.

In case the Policyholder or the Insured do not declare due to willful misconduct to the Company events or evidence that they are aware of, which are objectively essential for the estimate of the risk, the Company has the right to terminate the insurance policy within one (1) month, since the time the person was aware of the violation. In this case the claim will not bring immediate results. If the insurance case occurs within the above deadline, the Company is discharged of its liability to the payment of the sum insured and the Policyholder is obliged to restoration of any claim to the Company. Moreover, the Company is entitled to insurance premiums that were due at the time where the results of the termination occurred or at the time when the underwriting risk occurred.

ARTICLE 2. DEFINITIONS

a.	**The Company:**	European Reliance General Insurance Co.S.A. with headquarters in Chalandri, 274 Kifisias Avenue, p.c. 15232.
b.	**THE POLICYHOLDER:**	The person, natural or legal, that undersigns the insurance coverage and is obliged to pay the respective insurance premium and the full name or company name that is indicated in the first page of the insurance policy.
c.	**INSURED:**	The persons, members of Insured Team, for the life for which the insurance coverage is concluded.
d.	**BENEFICIARY:**	The person that is entitled to collect the sum insured, in case of occurrence of the underwriting risk.
e.	**SUM INSURED:**	The amount that, depending on the obligation, the Company is obliged to pay to the Insured or the Beneficiaries.
f.	**INSURANCE PREMIUMS:**	The amount payable by the Policyholder to the Company, in order for the Insurance Policy to continue to apply.
g.	**ACCIDENT:**	If the consequences that occurred to the Insured by a violent cause, external, accidental, visible, sudden and foreign to the intention of the Insured, provided that these consequences occurred immediately, exclusively and independently of any other cause within a time period of one hundred (180) days since the day of the accident.
h.	**DISABILITY:**	The bodily injury of the Insured, due to accident, over the policy period of the insurance policy, which has caused either loss of limb or body organ either defective, bodily or mentalfunction, temporary or permanent, partial or total and which requires medical treatment by a physician. All bodily injuries that exist simultaneously and are the result of the same or related causes will be considered as disability.
i.	**MEDICAL INSTITUTION:**	Any legally licensed hospital or clinic, fully equipped and manned by a legally qualified medical and nursing staff. The following are excluded from this category: physiotherapy centres, rest homes, nursing homes, institutions for drug addicts or alcoholics, old people's homes, rehabilitation institution, sanatoria and centres for

homeopathic treatment, acupuncture and cosmetic procedures.

j.	**PHYSICIAN**	Any person who holds a medical degree from a recognized Greek or foreign university and is licensed to practice medicine.
k.	**HOSPITALIZATION:**	Any treatment, surgery or medical procedure that must take place in a Hospital/ Medical Institution and for which the Insured is required to remain in such hospital for at least twenty-four (24) consecutive hours, due to accident or sickness. As hospitalization it is not considered the admission to a Medical Institution for diagnostic examinations, which is not followed by a medical treatment for cure of sickness or accident.
I.	**ENDORSEMENT:**	The document issued by the Company for any amendment of the present policy.
J.	**INSURANCE YEAR**	It is the continuous time period of twelve (12) months which begins from the Effective Date of the policy, as defined in the first page of the insurance policy and then after every Renewal Date.
K.	**TERRORIST ACTS:**	As terrorist act, we consider any act that includes the use or threat for use of violence or harmful substances or other dangerous methods or appliances, that is performed by a person or a group of people with political, ideological, religious or other similar motives, including (indicatively but not restrictively) the intention for intimidation or unfair coercion of the government or part of the population or destabilisation of any sector of the economy or disturbance of the public order.

ARTICLE 3. EFFECTIVE DATE - EXPIRY DATE

The Insurance Policy applies only when it is delivered to the Policyholderafter and the first annual insurance premium or the first installment of it is paid. Moreover, it is valid for the time period which is referred to in the first page of the insurance policy and it is renewed automatically in any anniversary for the time period of one year, provided the insurance premiums of the expired term have been paid in full, along with the insurance premiums or the first installment for the renewal of the insurance policy, unless the Policyholder or the Company notify to each other in writing the termination of the validity of the policy, no later than, thirty (30) days before the anniversary of the policy. According to the terms of the present article, the Company bears no liability for compensation, before the effective date of the insurance policy.

ARTICLE 4. TIME OF COVERAGE

The time of coverage of every insured begins from the date that is referred to as effective date of the relevant Endorsement, that declares the submission to the insurance coverage, under the prerequisite that the insured does not stay in the place of permanent residence and the policy ends, the same date as reported in the maturity date of the relevant Endorsement or the date that the insured will return to the place of permanent residence, in case that the duration of the journey is shorter than the predefined number of days.
The Company is not obliged to return the insurance premium or part of the insurance premium in case the Insured do not move, or in case the journey lasts for a shorter time period, or if it occurs in other dates, than those referred to the relevant Endorsment.

ARTICLE 5. PERSONS ENTITLED TO INSURANCE COVERAGE

With the present insurance policy, all person can be covered, that meet the requirements for the present insurance policy.
The present insurance policy excludes the following persons:
a. People age older than seventy-five (75) years old.
b. Persons that have become disabled, partially or totally, due to an accident, organic damage, surgery or disease, before their inclusion to the insurance coverage.
c. During their service with any type of relationship, type or form in the Armed Forces, in periods of peace or war.
d. That make use of narcotic or hallucinogenic substances, or are alcoholics.
e. Persons with permanent residence outside Greece, in the beginning of the policy period.

ARTICLE 6. BENEFICIARIES - ALTERNATIVE BENEFICIARIES

In case of death, the sum insured is paid to the Beneficiaries. In all other cases of compensation, the Beneficiary is the Insured.
Every Insured, may replace the Beneficiary/Beneficiaries, with a written statement to the Company. In the event of more than one designated Beneficiaries, the benefits of the Insurance Policy shall be allocated in

equal shares, unless the Insured decides otherwise. The rights of the Beneficiary shall be automatically waived in the event of death of the Beneficiary prior to the death of the Insured. In this case, and provided no substitute Beneficiary has been designated, then the benefits shall be paid to the heirs of the Insured, according to the regulation for the intestate succession. The same shall apply, if the Lawful Heirs of the Insured have been designated as the Beneficiaries. If no Beneficiary has been designated, then the benefits of the insurance policy shall be paid to the legal heirs of the Insured.
The Beneficiary, loses the right, if the beneficiary caused the death of the Insured or tried to kill the Insured [article 30/2 , L. 2496/97].

ARTICLE 7. INFORMATION REQUIRED FOR THE VALIDITY OF THE SCHEME

The Policyholder is obliged to provide to the Company, in the end of every month, the necessary files to monitor the course of the insurance coverage, such as the list with the names, variances, etc., as well as to declare within fourteen (14) days since the Policyholder was aware, every incident or case that could bring a significant aggravation of risk to the extent that if the Company was aware of it, it would not have undersigned the insurance coverage, or would not have undersigned it with the same terms.

Aggravation or variation of risk occurs, indicatively and not restrictively, when the insurance amounts change, when the number of the insured increases or decreases, when the insured use the same means of transport, etc. Possible mistakes in the information that the Policyholder provides to the Company, cannot harm the right of the Company in any way. In case of non provision of the above data, as date of variance, we consider the date of their written announcement.

ARTICLE 8. PAYMENT OF PREMIUMS

The insurance premiums are annual and prepaid and must be paid, without any prior notice of the Company to the Policyholder, the minimum within thirty (30) days before the indicated payment dates, upon printed receipts that have been undersigned by persons specifically authorized for this purpose. Any reminder by the Company for the payment of premiums cannot be considered as amendment of the above general regulation, excluding the invocation by the Policyholder of this event or another related practice. The payment of the insurance premiums is verified upon the presentation of special documents of the Company, excluding any other evidence. The delay in the payment of the overdue installment for the insurance premiums, apart from the aforementioned deadline, gives to the Company the right to terminate the policy with a written notice to the Policyholder with which the Company discloses that the delay for the payment of the insurance premiums will result, after the time period of one (1) month from the disclosure of the statement for termination of the insurance policy.

The Company is entitled to define new insurance premiums for every annual renewal of the insurance policy and for any other insurance coverage, with the consent of the Policyholder. However, before the renewal of the amount of the insurance premiums, the Company is obliged to inform the Policyholder with a letter of at least thirty (30) days, before the anniversary of renewal of the insurance policy.

ARTICLE 9. TERMINATION OF THE INSURANCE POLICY

The Company or the Policyholder may terminate this insurance policy any time, with a written warning of one month notice, before the end of the policy period.

1. Due to non-payment of the insurance premiums: The non-timely payment of the insurance premiums gives to the Company the right to terminate the policy, with written disclosure to the Policyholder that the delay in the payment of the insurance premiums will bring, after the time period of one (1) month, since the disclosure of the notification, the resolution of the insurance policy [article 6, L. 2496/97].

2. Inaccurate statement due to willful misconduct fraud: In case of fraudulent violation of the liability, provided in Article 3, par. 1 of L.2496/1997, the Insurer apart from the other rights that apply according to the aforementioned applicable Law, retains the right to terminate the insurance policy, within the deadline of one (1) month, after being informed of the violation.

ARTICLE 10. THE UNALTERED OF THE TERMS OF THE POLICY

If the Company does not apply or does not insist on the strict implementation of any term of the insurance policy, then this cannot be interpreted as resignation of the Company from the term or consent to its modification, neither can these terms be applied in another time period or circumstances.

ARTICLE 11. GENERAL EXCLUSIONS

No benefits shall be paid for claims arising directly or indirectly, partially or in total, from this Insurance Policy in the following cases or:

a. Intrusion or invasion of enemies, foreign or civil war, political or military sedition, rebellions, movements, uproar, strikes, requisitions, acts of usurpation of authority, terrorist acts, siege, attack from military weapons, means or activities.

b. Participation of the Insured in trainings or competitions for professional or amateur clubs of football, basketball, boxing, wrestling, acrobatics as well as in martial arts, competitions or trainings of speed or skill with any mean, diving, climbing with ropes, skiing, water skiing, paragliding, soaring, ballooning, parachuting and any kind of professional sports activity in general.

c. Service of the Insured, with any type of relation, or form in the Armed Forces in times of peace or war.

d. Accidents that may occur at a time when the Insured is under the influence of drugs, tranquillizers, stimulating substances or under the influence of alcohol (blood alcohol concentration higher than the legitimate limits).

e. Use of means of air transportation that do not belong to fully licensed airline carriers or that do not operate in scheduled flights, except for charter flights.

f. Pregnancy, childbirth, miscarriage, abortion, ectopic pregnancy or treatment for the improvement of the direct or indirect procreation abilities.

g. Congenital abnormalities and conditions that are caused or derive from these.

h. Direct or indirect effects of the transformation of the atomic nucleus and radiation caused by the artificial acceleration of atomic particles.

i. Frequent physical or other general test (check ups) when no objective indications arise for health damage or laboratory and X-ray tests, except if these occurred after an accident covered by this insurance policy.

j. Cosmetic or plastic surgery unless such surgery is required to correct bodily injury, due to accident covered by this policy.

k. Sicknesses, disabilities or bodily injuries, as well as their implications that occurred before the conclusion of the insurance coverage.

l. Cases that are due to epidemics, pandemics and infectious or contagious diseases.

m. Any nervous, mental conditions, psychotic disorders, as well as their consequences.

n. Participation of the Insured in the exercise or attempt to exercise illegal or criminal act.

o. Dental treatment, unless required to restore damage to natural teeth caused by an accident.

p. Suicide, suicide attempt or self-harm regardless of the mental state

q. Accidents that are due to earthquakes, volcanic explosions, floods, tornado or natural phenomena that can result to large-scale destruction.

It is explicitly stated that the Company is not obliged for compensation within the framework of the present insurance policy, if the payment of the compensation could expose the Company to the risk of imposition of penalty, prohibitions, or limitations, according to the decisions of the United Nations or based on the Laws or provisions related to economic or trade penalties of the European Union or Member State, United Kingdom , or United States of America.

ARTICLE 12. LIABILITIES IN CASE OF ACCIDENT

The Policyholder, the Insured or Beneficiary are obliged to notify in writing the Headquarters of the Company in Athens within eight (8) days for the death, within fifteen (15) days for every Other accident that is covered by this policy. Especially for cases of hospitalization, the Insured or the Beneficiary are obliged to inform in writing the Company before the exit of the Insured from the Medical Institution.

The Policyholder, the Insured or Beneficiary ought, in case of accident to provide to the Officers of the Company all details and accurate information related to the accident, to allow any legal examination or research, in order to identify the existence and extent of the accident. Moreover, they are obliged to provide at their own expenses any necessary certificate or document that can be used to prove the accident.

In case of violation or attempt of violation of these that are defined with the present article, directly or indirectly, that could create to the Company inaccurate knowledge on the risk, the Company is entitled to terminate the policy. If the violation has been caused be willful misconduct (fraud) of the Policyholder, the Insured or the Beneficiary, the Company has the right to request compensation for any damage caused.

Legal actions of the Company that aim to verify the conditions of the accident or their consequences, cannot be considered that they entail acknowledgment of the obligation for payment of the benefit.

After the audit of the evidence and acknowledgment by the Company of the right for provision of the benefit, according to the terms of this policy, the payment shall be made at the Headquarters of the Company.

ARTICLE 13. PAYMENT OF BENEFITS

The Company pays the benefits, either directly to the Insured or via the Policyholder who has the right to receive the benefits and proceed to compensation. In no case, should the validity of the payment of any benefit be doubted by the Insured, that took place via the Policyholder.

ARTICLE 14. DELEGATION

This insurance policy as long as any other rights deriving from this insurance policy may not be delegated without the written consent of both contributing parties.

ARTICLE 15. PLACE OF VALIDITY - CURRENCY

The present insurance coverage is valid in Greece. The insurance premiums and the sum insured are paid in Euro in the Headquarters of the Company.

ARTICLE 16. COURTS' JURISDICTION

Any difference that may rise directly or indirectly by the insurance policy is subject to the exclusive jurisdiction of the Courts of Athens.

ARTICLE 17. JUDICIAL ACTS - WRITE-OFF

Any difference that may rise directly or indirectly by the insurance policy is subject to the exclusive jurisdiction of the Courts of Athens.

Every claim that derives from this insurance policy will be written off after the expiry of the policy period, as provided by the Law. The write-off cannot be suspended for any reason, but can only be interrupted with an ordinary litigation and the administrative acts that follow.

ARTICLE 18. TAXES AND FEES

The taxes and fees that are imposed lawfully and refer to the payment of the insurance premiums burden exclusively the Policyholder and are paid along with the respective sum insured. Other taxes and fees that refer to payments of compensations of the sum insured burden exclusively the Beneficiaries of the sum insured.

ARTICLE 19. OBLIGATION OF THE POLICYHOLDER

The Policyholder is obliged to keep all general and special terms of the insurance policy and inform the Insured for any amendment or cancellation.

ARTICLE 20. THE FINAL PROVISION

For any matter that is not adjusted by the insurance policy, the Company shall apply the provisions of L. 2496/97 and L. 4364/16 for the insurance policy, as applicable and in force, as well as the other applicable provisions of the applicable Legislative.

ANNEX A

ARTICLE 1. SUBJECT OF INSURANCE

A. Death due to accident

In case that, as a result of the accident, the Insured dies or suffers bodily injuries that directly, exclusively and independent of any other cause, will result to death within a time period of one hundred eighty (180) days after the date of the accident and during the policy period, the Company shall pay to the beneficiary-beneficiaries, the Sum Insured of the benefit “Death due to Accident” as this is indicated in the Table of Coverages- Benefits of the insurance policy. In any case, the terms of the present Annex, provided they add a different adjustment, supersede the General Terms of the Group Insurance Policy.

B. Permanent Disability

B.1 Total Permanent Disability

If, due to accident, the Insured suffers bodily injuries that directly, exclusively and independent of any other cause, result to loss permanent, complete and definite, at the latest within one hundred eighty (180) days since the date of the accident, and during the policy period, loss of the capacity to exercise their previous employment or profession under payment or profit, the Company shall pay the Sum Insured of the benefit “Permanent Total Disability due to Accident”, as indicated in the Table of Coverages - Benefits of the insurance policy.

A necessary but not sufficient requirement for the payment of the benefit is that the rate of recognition of the disability by the Main Insurance Carrier amounts to at least sixty-seven percent (67%).

As total permanent disability we consider, the following:
- Total loss of function of both hands (below the wrist) or both feet (below the ankle) or the vision of both eyer or simultaneous loss of one upper and lower limp or one limp and one eye.
- The incurable traumatic or post-traumatic madness, as a result of the total disability of the Insured for work.
- Total paralysis.

B.2 Partial Permanent Disability

In case that, as a result of an accident that occurred within the policy period that is covered by the insurance policy, the Insured suffers bodily injuries, which directly, exclusively and regardless of any cause, would have as a result, the maximum within one hundred eighty (180) days, since the date, to decrease for life and in a substantial and definitive way his ability to practice any of his work with a profit, the Company will pay a percentage of the Insured Amount of the benefit "Permanent Partial Disability due to Accident", as stated in the Table of Covers-Benefits of the insurance policy, depending on the type of loss, as determined in the table below:

	RIGHT	LEFT
Total loss of the hand	60%	50%
Total loss of the movement of the shoulder	25%	25%
Total loss of the movement of the elbow or wrist	20%	15%
Total loss of thumb or index finger	30%	25%
Total loss of 3 fingers apart from the thumb	25%	20%
Total loss of thumb 1 finger apart from the thumb	20%	15%
Total loss of thumb	20%	15%
Total loss of index	15%	10%
Total loss of the middle finger or ring finger or little finger	10%	8%
Total loss of the 2 last fingers	15%	12%
Partial loss of foots with loss of all fingers	30%	30%
Total loss above or below the knee	50%	50%
Non-union fracture of the tibia or the leg	25%	
Non-union patellar fracture	20%	
Non-union tarsal fracture	15%	
Total loss of movement of the hip or knee	20%	
Total loss of the big toe	8%	
Total loss of a toe	3%	
Leg Length discrepancy of at least 5 cm	15%	
Total loss of an eye or decrease of the sight of both eyes to 50%	25%	

Total and incurable deafness of one ear	15%
Total and incurable deafness for both ears	40%
Non-union mandibular fracture	25%
Ankylosis of a segment of the spine or any spinal deformity	40%
Rib fracture accompanied with thoracic deformity and organ injuries	20%

If the Insured is left-handed, , the rates that are provided in the previous table for the different types of disabilities of the right and left hand are reversed.
The total and incurable loss of the ability to functionally use a limb, in a way that this becomes a useless limb, is considered total loss of limb.
In case of partial loss, that is when the use of the injured limb is partially hindered, then the compensation shall be equal to a rate of the amount that is provided for the case of total loss of limb, depending on the degree of hindrance of the use of the limb.
Any other case that is not provided by the above table, must be handled comparing to the above rates, to the extent that the overall ability of the Insured for work decreased.
If the consequences of the accident become even more serious due to the previous removal, amputation of a limb or physical defect,the compensation is estimated only for the injury that is connected directly to the accident and not for the larger injury that is connected indirectly by the pre-existing condition.
In case of an anatomical or operational loss of more limbs that is not related with total permanent disability, the loss is determined with the accumulation of rates that correspond to each injury, but can not be greater than the provided amount for the permanent total disability. In any case, the terms of the present Annex, provided they add a different adjustment, supersede the General Terms of the Group Life Insurance Policy.

ARTICLE 2. PAYMENT OF THE BENEFIT

If the underwriting risk occurs, the Company must receive immediately a written Statement to claim the payment of the sum insured.

After the identification of the total permanent disability, the coverage of the Insured from any other coverage that is provided by the insurance policy, ceases automatically to apply and the insurance policy is removed from the Group Life Insurance Policy.
The payment of the amount of the benefit occurs, when, after the receipt of the necessary documents, the following can be proved:

- The accident occurred at a time period when the Insured had valid insurance coverage according to the terms of the policy
- The underwriting risk occurred within a time period of one hundred eighty (180) days, since the date of the accident.
- The underwriting risk occurred immediately, exclusively and only after an accident and independent from any other cause.

2.1. In case of Death of the Insured, the Beneficiaries of the benefit must submit to the Company, the documentation mentioned below:

- Death Certificate of the Insured.
- Medical opinion on the causes of death. In case of a road accident, the incident report of the traffic police, the medical examination report and the case file are required.
- The Will of the Insured or the Certificate for Non-disclosure of the will by the competent by the Law Authority.
- Family Status Certificate, by the Authority that is competent by the Law.
- Certificate by the competent Tax Office on the declaration of the Sum Insured as an evidence of the inheritance.

2.2 In case of Disability, the Insured or the Beneficiaries are entitled to submit to the Company the documentation below:

- Accident Report with description of the causes and time of the incident.
- Official certificate/ disclosure of the Medical Institution, related decision for retirement by the Public Insurance Carrier i.e. IKA, TEVE], medical report of the competent Medical Committee, etc.

2.3 The Company retains the right to ask any type of documentation is considered necessary. The expenses that are required for the issuance of documentation burden the person with the claim for payment of the sum insured.

ARTICLE 3. CUMULATIVE COMPENSATION CASES

Im case an accident created a series of compensation claims by the present Annex, the Company is obliged to pay the highest compensation.

If before the payment of the compensation or part of it, due to permanent disability and within one hundred eighty (180) days since the date of the accident, death occurs, that is due directly and exclusively to the same accident, the Company shall pay any variance between the paid amount and the amount payable due to death.

ARTICLE 4. EXCLUSIONS

The General Exclusions of Article 11 of the General Terms of the insurance policy apply.

ANNEX B

008 MEDICAL EXPENSES DUE TO ACCIDENT

ARTICLE 1. SUBJECT OF INSURANCE

In case the Insured, as a result of an accident that occurred in the coverage year and that is covered by the insurance policy, is submitted to covered expenses, as those that are determined in Article 2 of this Annex, the Company shall pay the provided benefits, as indicated in the Table of Coverages - Benefits of the insurance policy. In any case, the terms of the present Annex, provided they add a different adjustment, supersede those of the Group Insurance Policy.

ARTICLE 2. COVERED EXPENSES

As covered expenses we considered the realized expenses that tool place for any of the following causes:

a. Room and Board during the hospitalization of the Insured.

b. Nursing services that were provided to the Insured during the hospitalization and include the following: Narcosis, laboratory and diagnostic examinations, bandages, plaster splints and casts etc., intravenous solutions, injections, serums, blood and plasma transfusions, oxygen, drugs, costs for the ICU, treatments with X-Rays, radioisotopes, services of licensed nurses,

c. In-hospital and out-of-hospital medical visits

d. Surgeries (including those that do not require hospitalization of the Insured), surgical accessories surgeon's and anesthesiologist's fees. The expenses for robotic ore remote surgery are not considered covered expenses and are not covered. As robotic surgery we consider any surgical act that takes place with the use of robotic systems. As remote surgery, we consider any surgical act that the surgeon performs with a tactical connection (control with feedback control system, etc.).

e. Anesthetics and oxygen.

f. Purchase of medicinal products after the prescription of a doctor.

g. X-Rays or treatments, laboratory and diagnostic examinations, inside and outside of the Medical Institution.

h. Blood or plasma transfusion.

i. Physiotherapies that take place after the accident that occurred during the submission of the Insured in Group insurance (with a referral not that indicates the reason for which the doctor recommends the treatment).

j. Medical Acts, which shall take place in an appropriate medical center (medical visits, emergency rooms, nursing institutions, diagnostic centers, etc.), without requiring treatment of the Insured, which will aim to handle, cure and restre any consequences of the accident of the Insured during the policy period and which is covered by this policy.

k. First Aid will be provided to the Insured in the place of the accident or during the transfer of the Insured in the medical center for the stabilization of the health in case of accident in the Insured during the policy period and which is covered by this policy.

The expenses that have been performed for services that are not necessary for the treatment of the Insured or expenses that exceed the usual and reasonable charge for corresponding medical or nursing activities or acts or expenses that have been compensated by another insurance carrier will not considered be covered.

As usual and reasonable charge, we consider the charge for provision of medical services within the Medical Institution, according to the overall price level, which does not supersede the respective charge for similar service in people with similar characteristics (age, type of sickness or accident).

ARTICLE 3. MAXIMUM INDEMNITY AMOUNT / REIMBURSMENT

As maximum indemnity amount it is defined the maximum amount for the coverage of expenses that the Company may have pay to every Insured in the policy period and which is determined in the Table of Coverages - Benefits of the Insurance Policy.
As reimbursement, we define the amount of participation of the Company to the recognized needs of the Insured, as defined in the Table of Coverages - Benefits of the insurance policy.

ARTICLE 4. PREREQUISITES

In case the underwriting risk occurs, the Company must receive, as soon as possible, a written request or the payment of the sum insured, along with the original perforated proof of evidence for the expenses, the medical opinion, doctor's prescription and receipt from the pharmacy in the name of the Insured, with the coupons for the medication (approved by the National Organization for Medicines), a doctor's prescription for laboratory - diagnostic examinations, as well as psychotherapeutic treatment.

The Company shall pay the sum insured in Euro, based on the foreign exchange conversion rates of the Bank of Greece at the day of payment of the receipts.

ARTICLE 5. EXCLUSIONS

Apart from the General Exclusions of Article 11 of the General Terms of the Insurance Policy, the present Annex does not cover the following cases and their direct or indirect consequences:

a. Expenses for Robotic or Remote surgery

ANNEX C

021 EXPENSES FOR EMERGENCY TRANSFER

ARTICLE 1. SUBJECT OF INSURANCE

In case that, if due to an accident an emergency event occurs, that took place within the policy year of the Insured, the extraordinary transfer of the insured in the Medical Institution is required and will pay the usual and reasonable expenses for health care transfer in the closest Nursing Institution, with maximum limit the amount referred to in the Table of Coverages- Benefits of the insurance policy. As expenses for medical health care we consider the expenses for transfer under medical observation in the closest medical Nursing Institution or the place of permanent residence, as well as the expenses for medical services and medical materials, necessary for the duration of the extraordinary transfer.

ARTICLE 2. PREREQUISITES

In case the underwriting risk occurs, the Company must receive immediately a written statement for the claim for payment of the sum insured. The required conditions for the completion of the payment are the following:

- The accident or the emergency case of sickness took place in the policy period.
- The insurance risk occurred immediately, exclusively and only by an accident or emergency heath event that is covered by the insurance policy.
- The accident or the emergency event of sickness need to be proved, based on the attached documentation.
- To provide the necessary medical care, for the stabilization of the health of the Insured and the medical doctor would provide in writing that the direct transfer of the Insured in an adequate Nursing Institute is required.
- The expenses for the transfer took place with the most direct and financially available means of transport.
- All documentation and original receipts should be submitted to the Company, the minimum within two (2) months, since the date of the accident. In this case, all required documents must be stamped by the local Greek Consulate of the country and be translated in Greek.

ARTICLE 3. EXCLUSIONS

The General Exclusions of Article 11 of the General Terms of the insurance policy apply.