Accident Health and Liability Insurance for Austria

Let us help you understand how the insurance will work for your students! ☺

Due to inadequate or insufficient insured students and au-pairs in the past, the Austrian Foreign Ministry ruled that non-EU students who want to stay in Austria for more than 90 days must have a comprehensive insurance.

Students applying for a visa will have to send the detailed insurance documents along with the visa application papers. The Austrian state will not accept any foreign insurances, regardless of their extensive coverage. Fortunately, Into Austria has negotiated a package and price with the insurance provider UNIQUA for our exchange students. This insurance is accepted by the Austrian Foreign Ministry and will enable an incoming student to obtain their visa without any problems.

Below you will find the insurance form that must be filled out and signed (mandatory filled are marked in red), as well as information on what is covered. Please have the student and his/her parents fill in the form and send it to us as a PDF. We will take care of the rest, forward the documents to the insurance company and provide you with all the necessary documents to add to the visa application.

Upon arrival your student will receive their own insurance card that they will have to show by going to the doctor. In some cases, the student may need to pay the doctor's visit in person. In this case he/she needs to keep the receipt and send it to us so that we can take care of the claim and reimbursement.

For any further questions please do not hesitate to contact us!

UNIQA

UNIQA Österreich Versicherungen AG
A-1029 Wien, Untere Donaustraße 21, Tel. +43 (0) 50677
Sitz: Wien, FN 63197m Handelsgericht Wien, DVR: 0018813

Health & Valuable
Health Insurance with final statement

Proposal

Summary proposal for: ☐ Special class Select Compact ☐ Special class after accident ☐ FirstCare ☐ Per diem up to EUR 70.00 ☐ Travel ☐ VitalPlan* ☐ Transition care* *cannot be taken out separately

Policy number
old | new

Policyholder is insured person? ☐ Yes ☐ No — IP 1
Surname, first name, title | exact title of occupation/subsidiary occupation
Street, square, house number, staircase, top, tel. no. | E-Mail
Postal code | Place of residence | Social security | Soc.sec.no.
Marital status | Date of birth YYYY/MM/DD | ☐ female ☐ male | number of children living in the same household

Versicherte Personen
IP 2
Surname, first name, title | previous surname
Marital status | Date of birth YYYY/MM/DD | ☐ female ☐ male | Social security | Soc.sec.no.

IP 3
Surname, first name, title | Date of birth YYYY/MM/DD | ☐ female ☐ male | Social security | Soc.sec.no.

IP 4
Surname, first name, title | Date of birth YYYY/MM/DD | ☐ female ☐ male | Social security | Soc.sec.no.

Tariff selected
☒ ~~Minimum insurance period 3 years~~

IP 1		
IP 2		
IP 3		
IP 4		
Tariff		Monthly premium in euro

Date of inception YYYY/MM/DD | Tax confirmation: ☐ Yes ☐ No | Total premium new incl. insurance tax EUR

Payment period Payment method
☐ monthly ☐ quarterly ☐ half-yearly ☐ yearly ☐ Direct debit mandate (Please fill in form) ☐ Payment slip (EUR 2.00 as additional expense for service)

Questions related to the health of the persons to be insured

Have the persons to be insured been treated for any of the following diseases or consequences of an accident or have they occurred at any time: cancer, stroke, heart attack, chronic heart diseases, neurologic diseases such as multiple sclerosis, Morbus Parkinson, mental illnesses (including mental handicaps, dementia), chronic lung diseases, chronic inflammable bowel diseases, kidney failures, body mass index above 39 (excessive overweight), bone disease, diabetes, chronic liver disease, chronic polyarthritis, HIV positive findings, cerebro-cranial trauma, paraplegia, blood-clotting disorders, eye diseases which can lead to severe visual impairment (macular diseases, retinal diseases, glaucoma)?

	IP 1	IP 2	IP 3	IP 4
Is an inpatient hospital stay or a stay at a health resort or rehabilitation centre planned or has such stay been advised by a doctor?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Is sport your principal occupation?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

If any of the above questions is answered with ‚yes', the insurance policy can only be applied for after detailed questions regarding the health of the person to be insured have been answered. The insurer decides on the acceptance of the proposal.

The contract does not become effective before the insurance policy is received. There are no oral ancillary agreements. I furthermore confirm receipt of the proposal for an insurance proposal and of a copy of the insurance proposal. By signing this document I accept that explanations and notes, in particular my consent to the collection, transmission and other use of data, become part of the proposal.

I/we declare that all answers given are correct and complete, also where this proposal has been filled in by a third party. If a circumstance, the disclosure of which has been requested in written form, is not disclosed, the insurer may terminate the contract or refuse to pay benefits under the policy.

Signature: Broker | Place, date | Signature of the person(s) to be insured | Signature: Policyholder and/or legal representative

1697– 05.2013

X Please tick, where applicable!

3. Direct Settlement Mandate

Under medical expenses insurance, the policyholder/primary insured or the insured person(s) can issue a mandate for direct settlement of insurance claims between the insurer and the healthcare provider. Before issuing a concrete mandate, the doctor or the institution whose services are to be settled shall be informed that the insurer is entitled to collect the following personal health data for direct settlement purposes.

a. for obtaining a cover note
- data identifying the policyholder/primary insured or the insured person(s),
- data regarding the insurance relationship and the admission diagnosis (data on the reason for admission as inpatient or for outpatient treatment and data regarding the question whether the treatment is due to an accident);

b. for settling and verifying the service
- data on treatment services provided (data regarding the reason for a treatment and its extent) including the surgical report;
- data on the length of inpatient or outpatient treatment;
- data on the discharge from hospital or the termination of treatment.

The policyholder/primary insured or the insured person(s), whose data are to be collected, may prevent the transmission of data from the doctor or healthcare provider to the insurer at any time. This can have the effect that the insurer first at least suspends cover and the policyholder/primary insured remains liable to pay for the services which would otherwise be covered.

4. Release from the Obligation of Confidentiality

The proposer (the policyholder/primary insured) and the person(s) to be insured releases (release) the persons referred to in paras. 1, 2 and 3 in advance from their medical and other professional confidentiality obligations and from the obligation to maintain official secrecy in accordance with the declaration of consent.

II. OTHER DATA

1. Consent to the collection and use of other personal data

The proposer (policyholder/primary insured) and the person(s) to be insured explicitly agree that the insurer shall be entitled to transmit personal identification data (name, date of birth), registration data, registration status data and insurance claim data [no health data or sensitive data (racial or ethnic origin, political, religious or philosophical belief, sexual life, trade union affiliation)] to other insurance companies in Austria and to receive such data from them in order to assess whether and under what conditions an insurance policy has been taken out, amended or renewed and in order to assess and fulfil claims arising under the policy after an insurance claim has occurred. The aforesaid persons agree to the transmission of the following data to companies entrusted with the processing of assistance cases under an assistance insurance. Name, date of birth, address, insurance contract data.

2. Consent to the use of personal data under the ZIS

The Zentrale Informationssystem (ZIS) (Central Information System) of the Austrian Association of Insurance Companies, 1030 Vienna, Schwarzenbergplatz 7 is an institution of the insurance sector designed to prevent and combat money laundering and insurance fraud and a joint information system for the purposes of § 4 (13) DSG 2000. **The proposer (policyholder/primary insured) and the person(s) to be insured explicitly agree that the insurer** shall be entitled to transmit personal identification data (name, date of birth), registration data and registration status data as well as information about the class of insurance concerned (no health data) under the ZIS in individual cases to other insurance companies in Austria and to receive such data from them in order to assess whether and under what conditions an insurance policy has been taken out, amended or renewed and in order to assess and fulfil claims arising under the policy.

3. Other Use of Data

The proposer (policyholder/primary insured) and the person(s) to be insured agree that the insurer shall be entitled to use personal identification data and contract data (e.g. type of contract, duration, sum insured; no sensitive data) for advice on other financial services products. Proposals regarding other financial services products may be submitted to you (them) by fax, e-mail etc. The above-mentioned data may be used also by group and partner companies (UNIQA Versicherungen AG, UNIQA Österreich Versicherungen AG, Raiffeisen Versicherung AG, SALZBURGER Landes-Versicherung AG, FINANCE LIFE Lebensversicherung AG, UNIQA Finanz-Service GmbH) for the purpose described above. ☐ yes ☐ no

The declarations of consent pursuant to clause II. may be revoked at any time.

Please answer both questions by ticking the appropriate box!

Place, Date	Signature of the policyholder/the primary insured	Signature(s) of the person(s) insured
		X

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Declaration of consent to the collection and use of personal health data and, to the release from confidentiality with respect to personal health data and to the collection and use of other data

I. PERSONAL HEALTH DATA

The collection and use of your personal health data under the insurance policy requires your explicit consent. In addition, it is necessary that you release persons or bodies subject to confidentiality obligations (e.g. doctors, hospitals) from their confidentiality obligation to not transmit such data to third parties. You may give your consent to such release from confidentiality also to the insurer so as to enable it to collect your data directly from the bodies concerned by submitting the declaration of consent to the release from confidentiality.

1. Personal health data in relation to the conclusion/amendment of insurance policies

The proposer (policyholder/primary insured) and/or the person(s) to be insured give their explicit consent that, in order to assess whether and under what conditions the proposed insurance contract or the proposed amendment to the insurance contract can be concluded or performed, personal health data may be collected on the basis of indispensable information by the examining or treating doctors, hospitals, other (preventive) healthcare institutions and the notified social insurance institutions.

‚Indispensable information' means all information required for giving an assessment on the conclusion of the insurance contract or an amendment thereto and/or documents from doctors or other bodies subject to confidentiality obligations. It includes, in particular, required medical documents (medical history, discharge summaries, histologic and laboratory findings, all diagnostic findings, infusion sheet, clinical or medical admission and treatment data). In individual cases, the submission of fewer documents may be sufficient. This consent can be revoked at any time. A revocation has the consequence that the insurer may either reject the proposal or accept the proposal only under modified conditions and/or stop processing it until the required documents are submitted. In such case, cover will be limited or no cover will be provided.

2. Personal health data in relation to insurance claims

The proposer (policyholder/primary insured) and/or the person(s) to be insured consent that the insurer collects his, her or their personal health data to assess its obligation to provide cover subject to the following conditions:

Pre-authorisation:

The proposer (policyholder/primary insured) and/or the person(s) to be insured has (have) taken careful note of the instructions on the possibility of a one-time authorisation and consents (consent) to the direct collection of personal health data by the insurer to enable it to assess, on a case-by-case basis, its obligation to provide cover where indispensable information is required from examining or treating doctors, hospitals or other institutions subject to confidentiality obligations.

‚Indispensable information' for the purposes of the preceding paragraph means information from the above-mentioned doctors, hospitals and other (preventive) healthcare institutions on diseases, health damage, appearances of attrition, physical defects and consequences of accidents related to the specific insurance claim required by the insurer in individual cases to assess its obligation to provide cover.

It includes all medical documents (data on the reasons for inpatient or outpatient treatment, the reasons for an accident, the treatment provided, the length of inpatient or outpatient treatment and the discharge from hospital or the termination of treatment, in particular the history of the current treatment/admission as well the status sheet, the temperature chart with infusion plan, all diagnostic findings, surgical reports, medical progress reports, anaesthetic reports, nursing progress reports, discharge summaries, forensic findings, rescue operations reports and reports of public authorities. The submission of fewer documents may be sufficient in individual cases).

☐ yes ☐ no

The proposer (policyholder/primary insured) and the person(s) to be insured may revoke a pre-authorisation for collection of personal health data given to the insurer at any time.

The consent to a pre-authorisation has the following legal consequences for the purposes of § 11a (2)(4) VersVG: Before obtaining the consent of a person concerned (policyholder/primary insured or insured person), the insurer shall notify the person concerned in writing of the intended collection of information required for assessing and fulfilling claims under the policy, specifying the exact data to be collected and the purpose of the intended data collection. The person concerned may object in writing to the intended data collection within 14 days after receipt of such notification, such objection to be received by the insurer within that period, failing which the insurer shall be entitled to obtain the information in accordance with the present declaration of consent. Together with the notification of the intended data collection, the insurer shall instruct the person concerned about his or her right of objection and the consequences of such objection in a clear and comprehensible way.

If no pre-authorisation has been granted, the collection of data shall be authorised on a case-by-case basis.

Instead of granting a pre-authorisation (as described above), the proposer (policyholder/primary insured) and/or the person(s) to be insured may also consent subsequently, on a case-by-case basis, to the collection of his or her (or their) personal health data necessary for the insurer to assess its obligation to provide cover also when concrete insurance claims arise. If such declaration of consent is made subsequently, the assessment of the insurer's obligation to provide cover can be delayed. If no such consent is given on a case-by-case basis, the policyholder/primary insured or the person(s) insured shall obtain (to the required extent) information necessary for the insurer to assess and fulfil claims arising under the policy himself or herself (or themselves) and provide it to the insurer. Before the insurer receives the data necessary for it to assess its obligation to provide cover, claims to benefits under the policy shall not become due. If no data is provided at all, the insurer may be released from its obligation to provide cover.

In the case of revocation of the declaration of consent or in the case of an objection against the collection of data in accordance with the pre-authorisation, intended and notified by the insurer, the policyholder/primary insured or the person(s) insured shall obtain (to the required extent) the information necessary for the insurer to assess and fulfil claims arising under the policy themselves and send it to the insurer. Before the insurer receives such information, claims to benefits under the policy shall not become due.

The proposer and the person to be insured furthermore agree that the insurer shall be entitled to obtain information from social security institutions, public health financing funds and private insurance companies about any personal insurance of the proposer or the person to be insured proposed, existing or terminated (with respect to double insurance).

Explanations and notes

Pre-contractual duty of notification
The proposer is obliged under § 16 Versicherungsvertragsgesetz (VersVG) to answer all questions in the proposal, in particular those relating to his or her health, occupation and/or leisure activities, correctly and completely. The provision of incomplete or incorrect information prevents the insurer from correctly assessing the risk of the person to be insured. In the case of culpable violation of this duty, the insurer may, under certain circumstances, terminate the contract and refuse to pay benefits.

Responsibility for the proposal
The questions in the proposal must be answered correctly and completely, failing which the insurer may terminate the contract and/or refuse to pay benefits. The proposer is solely responsible for the correctness of the information provided in the proposal, even if he or she has not filled it in himself or herself. The broker is not entitled to make binding statements about the meaning of questions in the proposal or about diseases. All statements must be laid down in writing in the proposal. Special written agreements and reservations must be confirmed by the insurer.

Commitment period: The proposer shall remain bound by this proposal for four weeks of the proposal date.
Important notice: For legal reasons, the applicable UNISEX legislation shall apply to all policies issued after 17 December 2012, irrespective of any proposal and/or application already issued.

Inception of Cover
The submission of a proposal does not constitute an insurance contract. Insurance cover begins in accordance with the contractual terms upon receipt of the insurance policy or a separate declaration of acceptance and upon payment of the premium at the time stated in the policy.

Duty of notification in the case of an increase of risk before receipt of the insurance policy
The proposer shall immediately notify the insurer in writing of any changes in his or her health (complaints, illnesses, injuries), a pregnancy, changes in his or her occupation and the insured person(s) that occur until receipt of the insurance policy and/or until a later inception date.

Right of Termination
The proposer may terminate the contract by giving written notice within 31 days after receipt of the insurance policy and, where the proposer is a consumer, after receipt of the notice concerning his or her right of termination. The notice period shall be deemed complied with if the proposer has dispatched his notice of termination within that period. The proposer's rights of termination are laid down in §§ 3, 3a KSchG, as well as in §§ 5b, 5c VersVG. For the exact wording of the law, please visit our web site at: www.uniqa.at. We will send you the relevant pieces of legislation free of charge upon request.

Notes regarding the provisions for equal treatment of people with disabilities:
The policyholder or the insured person(s) can request a justification if, for risk-related reasons, the health information provided results in a rejection or a requirement for an agreement regarding a premium supplement, a risk exclusion, a reduction in benefits, or a particular waiting period, as long as the insurer is supplied with a certificate of disability (e.g., a valid disability pass from the Federal Social Office or a valid employment certificate under the Disabled Persons Employment Act).

Supervisory authority
Financial Market Authority, Otto-Wagner-Platz 5, 1090 Vienna

Insurance tax
The current insurance tax is 1% of the premium.

Incidental charges
Besides the premium, only those costs will be charged that need to be paid to cover additional expenses caused by the policyholder.

Waiver of termination: Agreement pursuant to § 8 (2) VersVG
The proposer waives his or her right of termination for a period of 2 years, which means that the policy can be terminated for the time at the end of the third insurance year. The notice period is 1 month.

Legal bases
The proposed insurance is based on the current tariffs and/or tariff provisions, the Terms and Conditions of Insurance and the Versicherungsvertragsgesetz (VersVG). Austrian law shall apply.

Wie erreichen Sie uns am besten?

- Wir geben Ihnen gerne weitere Informationen telefonisch rund um die Uhr unter +43 (0) 50677-670.
- Wenn Sie persönlichen Kontakt wünschen, wenden Sie sich bitte an eine/n unserer Betreuerinnen oder einen unserer ca. 400 Standorte in Österreich.
  Den nächsten Ansprechpartner finden Sie am leichtesten auf www.uniqa.at unter „Standortsuche".

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1697–05.2013

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Insurance coverage for stays abroad

with stable value

Europe without Switzerland*
Expatriates Gold
QEXPYA 3 2017/B

The following benefits are available up to a maximum amount of ..... EUR 2.602.000,00 per calendar year.

I. In-hospital treatment (Items 5.8. to 5.14. of the General Conditions of Insurance); Item A. Supplementary Insurance Conditions)

The insurance coverage includes services for medically-indicated in-patient hospital stays in the general fee category of a general public hospital in Europe (see Europe List) due to illness, accident or child delivery to the following extent:

1. FULL GUARANTEE OF COST COVERAGE

1.1. In case of in-patient hospital stays in the general fee category of a general public hospital in Europe (see Europe List), the costs are paid fully and directly, insofar as UNIQA SOSservice (see SOS card) is contacted before the in-patient admittance and it handles the insurance case.

1.2. If UNIQA SOSservice (see SOS card) is not called upon the costs of an in-patient hospital stays in the general fee category of a general public hospital in Europe (see Europe List) are reimbursed upon presentation of the settled original invoice less a 20% excess. The excess amounts to a
a maximum of ..... EUR 3.900,00
per hospital stay.

The excess will not be deducted if the urgency of the in-patient treatment does not allow the prior establishment of contact with UNIQA SOSservice and its handling of the insurance case.

2. ACCOMPANYING PERSON

For hospital stays of children up to age 18 insured according to this tariff, the costs for an accompanying person
- are paid in full if the stay is reimbursed according to Item 1.1
- if the stay is as listed in Item 1.2, the costs will be reimbursed upon presentation of the settled original invoices less a 20% excess. The excess amounts to a
maximum of ..... EUR 390,00
per hospital stay.

The excess is omitted if no excess is applicable for the in-patient stay of the insured child.

3. PER DIEM HOSPITAL ALLOWANCE, CHILD DELIVERY FLAT FEE

If no costs arise for the insurer for an in-patient hospital stay, a daily hospital allowance
of ..... EUR 156,00
will be paid, in the case of child delivery a child delivery flat fee
of ..... EUR 1.560,00
will be paid.

II. Day hospital or day clinic area (supplementary to Item 5.8 and in amendment to Item 5.10. of the General Conditions of Insurance); Item A. Supplementary Insurance Conditions)

1. If a medically-indicated treatment in Europe (see Europe List) requires a hospital stay of less than 24 hours and an overnight stay is not medically necessary, insofar as UNIQA SOSservice (see SOS card) is contacted and it handles the insurance case, the costs will be paid in full. In cases in which direct settlement is not possible, the costs will be reimbursed upon presentation of the settled original invoice.

2. If UNIQA SOSservice (see SOS card) is not called upon, the costs of the day hospital or day clinic treatment in Europe (see Europe List) will be reimbursed upon presentation of the settled original invoice less a 20% excess. The excess amounts to a maximum
of ..... EUR 3.900,00
per treatment.

The excess will not be deducted if the urgency of the in-patient treatment does not allow the prior establishment of contact with UNIQA SOSservice and its handling of the insurance case.

III. Patient transport (supplementary to Item 5.12. of the General Conditions of Insurance); Item A. Supplementary Insurance Conditions)

1. Cost reimbursement for medically-indicated transports in Europe (see Europe List) for a treatment according to Item I or Item II amounts to
a maximum of ..... EUR 1.950,00.

2. Insofar as for medical reasons a medically-indicated transport is only possible via helicopter, the annual maximum amount listed under Item I
increases to ..... EUR 3.900,00.

IV. Out-patient treatment (Items 5.2 to 5.7 and 5.13 to 5.15 General Conditions of Insurance; Item A. Supplementary Insurance Conditions)

The insurance coverage includes services for medically-indicated out-patient treatments in Europe (see Europe List) due to illness, accident or pregnancy to the following extent:

1. The full costs will be reimbursed for:

a) Out-patient medical treatment (including complementary medicine)
b) Medically-indicated medicines (including homeopathic remedies)
c) Medically-indicated auxiliaries (treatment aids)
d) Medically-indicated physiotherapeutic treatment (treatment aids), ergotherapy, logopedics
e) Medically-indicated psychotherapeutic treatment provided by persons who are authorised to practice psychotherapy independently

up to a total of ..... EUR 6.500,00
per calendar year.

In case of life threatening disease (oncological illness, immune - or autoimmune disease respectively dysfunction of blood coagulation) and after reaching the above mentioned maximum rate for outpatient reimbursement, the costs are paid fully for medically indicated drugs and blood substitute.

Up to this maximum rate expenses will be reimbursed for -Visual aids (glasses and contact lenses) per two calendar years up to ..... EUR 390,00.

If the annual maximum amount listed under item IV.1. has been exhausted, 80% of the costs for

a) out-patient medical treatments (item IV.1.a)

- per medical consultation up to ..... EUR 48,70
- per specialised medical consultation up to ..... EUR 77,90
- per medical housecall up to ..... EUR 77,90

b) out-patient medical special services (e.g.: injections, infusions, EKG)

- per medical consultation up to ..... EUR 97,40
- per specialised medical consultation up to ..... EUR 155,80
- per medical housecall up to ..... EUR 155,80

2. For medically-indicated dialysis,

- in contracting facilities, the full costs
- in all other cases, per treatment up to EUR 390,00

will be paid.

V. Dental treatment (Items 5.2. and 5.5. as well as 5.13. and 5.14. of the General Conditions of Insurance); Item A. Supplementary Insurance Conditions)

The insurance coverage includes benefits for dental treatment in Europe (see Europe List) to the following extent:

80% of the costs will be reimbursed per calendar year for:

a) Preservative dental treatment
b) Dental x-rays
c) Tooth extraction
d) Prosthetic care (e.g. crowns, bridges)
e) Oral surgery
f) Dental implantology
g) Periodontosis
h) Dentofacial orthopedics
i) Prophylactic measures to help preserve and maintain teeth such as oral hygiene, removal of dental calculus, fluoridation and fissure sealing

up to a total of..... EUR 3.250,00
per calendar year.

Up to this maximum rate expenses will be replaced for -Dentofacial orthopedics up to a total of ..... EUR 650,00.

If this annual maximum amount is exhausted, for additional dental consultations, up to ..... EUR 236,30 is available per calendar quarter.

VI. Child delivery at home (Item A. Supplementary Insurance Conditions)

For a child delivery at home in Europe (see Europe List), ... EUR 1.560,00 is reimbursed in lieu of all other benefits.

VII. Rehabilitation (in amendment to Item 5.10. of the General Conditions of Insurance); Item A. Supplementary Insurance Conditions)

The costs of a medically-indicated in-patient rehabilitation treatment in Europe (see Europe List) related to previous insured in-hospital treatment due to a cardiac or circulatory illness, TBC illness or due to an accident will be reimbursed per day up to ..... EUR 195,00, for a maximum of 90 days.

VIII. Cure (in amendment to Item 5.10. of the General Insurance Conditions)

For medically-indicated rehabilitation stays in Europe (see Europe List), that have been prescribed by a physician and for which the cost of the therapy and stay have been verified, a rehabilitation per diem allowance of ..... EUR 45,50 is paid during a 2 calendar year period for a maximum of 28 days.

IX. Rescue costs (Item A. Supplementary Insurance Conditions)

Rescue costs in Europe (see Europe List) will be reimbursed per case up to ..... EUR 1.950,00.

X. Patient repatriation and transport of a deceased person (supplementary to Item 5.12. of the General Insurance Conditions; Item A. Supplementary Insurance Conditions)

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1. Patient repatriation

The insurance coverage includes services for patient repatriations in Europe (see Europe List) due to illness or accident to the following extent:

the full costs will be reimbursed for:

a) a medically-indicated patient repatriation from the European foreign country to a hospital in the dispatch or homeland or to the residence in the dispatch or homeland.

b) The transport of a person close to the person transported

The patient repatriation must be organised by UNIQA SOSservice (see SOS card), otherwise a maximum of ..... EUR 2.470,00 shall be reimbursed.

The aforementioned benefits will not be paid if the patient repatriation is in conjunction with a planned treatment.

2. Transport of a deceased person

The full costs of standard transport of a deceased person within Europe (see Europe List) to their home will be reimbursed.

The transport must be organised by UNIQA SOSservice (see SOS card), otherwise up to ..... EUR 1.040,00 will be reimbursed.

A. Supplementary Conditions

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1. Waiting periods (Item 3. of the General Conditions of Insurance)

The general waiting period does not apply.

The special waiting period for benefits according to Item V (dental services) - excluding dental treatments, which serve the immediate purpose of preventing pain and first aid after accidents - as well as for child delivery, miscarriages, pregnancy check-ups and pregnancy-related disorders and their consequences is 8 months. Insurance coverage is provided for premature child delivery or

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miscarriages that under normal circumstances would have led to childbirth after 8 months.

2. Cost coverage guarantee

The prerequisites for the cost coverage guarantee and direct settlement in the (listed) hospitals under contract are (furthermore)

- a valid mandate for direct settlement, which was granted for the specific service and
- a valid individual consent declaration for the case that further health data are required for the examination.

3. Dental and dentofacial treatments

The reimbursement of costs for dental and oral surgery treatments as well as tooth x-rays is strictly in accordance with Item V (dental treatment).

4. Out-patient treatment (Item IV)

In addition to Items 1.2. and 5.15. of the General Conditions of Insurance the insurance coverage also includes treatments provided by a physician in accordance with complementary medical findings (curative methods such as homeopathy, acupuncture, chiropractics), including homeopathic remedies prescribed by a physician.

5. Rehabilitation (Item VII)

Insurance coverage is provided for rehabilitation treatments in suitable, in-patient facilities recognised by the authorities.

6. Rescue costs (Item IX)

Rescue costs are the confirmed costs of searching for the insured person and their transport to the next passable road or to the hospital nearest the accident location.

They will be reimbursed if the insured person has suffered an accident or has fallen into distress in the mountains or water and must be rescued, injured or uninjured, or if they have been killed as a consequence of distress in the mountains or water and their body must be recovered. Equivalent to an accident is if the insured person has to be rescued immediately due to a health event.
The benefit for rescue by helicopter is paid if the rescue could not be performed in any other way.

7. Patient repatriation (Item X)

a) The prerequisite for patient repatriation is, in addition to the ability of the insured person to be transported, that:

- there is a life-threatening disturbance of his/her state of health

- an in-patient hospital stay of more than 5 days can be expected.

b) in case of a patient repatriation, the UNIQA SOSservice must be informed. In order to be able to take the required measures, the SOSservice requires the details requested on the SOS card. Based on the details communicated, the SOSservice contacts the treating physician and decides given the criteria specified in Item a) about the execution and type of transport (depending on the situation using an ambulance, train, passenger airplane or ambulance jet). The decision is made in cooperation with the physicians treating on location; however the final decision will be made by the SOSservice physician.

8. Payment of the insurance benefit

Complementing Article 7 of the General Insurance Conditions, invoices must be presented in German, English or French.

9. Secondary liability

Any existing legal social insurance or other private insurance as well as claims based on legal provisions or agreements must be claimed preferentially. If UNIQA has paid benefits, then equivalent claims of the insured party against third parties are transferred to them.

10. End of work abroad, return to the permanent place of residence, relocation abroad

The insurance coverage (tariff) is based on a secondment abroad or temporary work abroad. An adjustment to the insurance is required in the following cases:

- end of the secondment abroad or temporary work abroad
- a return to the permanent place of residence (home country)
- a relocation of the permanent place of residence abroad

The insurer must be notified immediately if one of these events occurs in order to ensure that appropriate insurance coverage is still maintained. The insurer will then make an adjustment to the tariffs in line with the new circumstances.

B. Benefit and premium adjustments

1.a) UNIQA commits itself to maintain the value of its insurance coverage or adjust its benefits in the case of a change in the price of health-care services so that the cost coverage guarantee remains in all items in which it is explicitly provided.

b) An adjustment must also be made if the following circumstances or factors change:
- The average life expectancy
- The frequency with which benefits are claimed

2. The benefit adjustment for Items I., II. and X. must be made in accordance with the change in the prices of the health-care services as well as of the contractual partners.

For all other items, adjustment shall be made based on a comparison of the latest European consumer price index (ECPI) with the index of the previous year or with the index on which the last adjustment was based. The fixed excesses must also be adjusted according to this index.

Any changes in health care or the applicable legal provisions that make a change in the benefits necessary must also be taken into account when adjusting those benefits.

3. The adjustment of the benefits must occur without age limit, waiting period for additional services, and regardless of any decline in health condition.

4. The new calculation of premiums shall be based on the benefit adjustment according to Items 1 and 2 and shall take into consideration changes in average life expectancy, the frequency of utilisation of benefits and their cost, and the health system or governing legal provisions.

5. The new services and premiums shall become effective on the 1st of the month after the insured person is informed in writing.

6. For one month, the insured person shall be entitled to refuse the adjustment of services and premiums in writing. In such a case, the insurance shall be continued at a substitute tariff with a change in benefits.

C. Miscellaneous

SOS card

For in-patient, day hospital or clinic treatments as well as for patient repatriations and the transport of a deceased person, please make contact with UNIQA SOSservice at the telephone number on the SOS card.

EUROPE LIST

Albania
Andorra
Austria
Belarus
Belgium
Bosnia-Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Macedonia
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Italy
Latvia
Liechtenstein
Lithuania
Luxemburg
San Marino
Malta
Moldova
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Roqania
Russia
Serbia
Slovakia
Slovenia
Spain
Sweden
Turkey
Ukraine
United Kingdom of Great Britain and Northern Ireland

* Insurance coverage in Switzerland only applies to primary care after an accident, in a suitable hospital located closest to the site of the accident.

Adjustment of premium of a comparable tariff QEXP 3 2016 over a period of the last 5 years:

Year	Increase per %
2016	3,48
2015	3,48
2014	2,87
2013	3,00
2012	3,60

The adjustments of premium in the past do not allow any conclusion for the future progression of the premium level.