General Terms and Conditions
Individual WARTA Your Health Plus Life Insurance
GTC Code: PZCITI2/06/2017

Information prepared in accordance with Article 17 of the Act on insurance and reinsurance activities, approved by Resolution no. 131/2017 of the Management Board of TUnŻ "WARTA" S.A. and brought into effect on 30 June 2017.

INFORMATION TYPE	RELEVANT PROVISIONS IN STANDARD CONTRACT
1. Conditions for paying claims and other benefits or the surrender value	§ 2 Section 2 § 7 § 8 Appendix to the GTC
2. Limitations and exclusions of liability authorizing the Insurer to refuse to pay or reduce claims or other benefits.	§ 2 Section 3, Section 5-8 § 4 Section 2 § 8 Section 14 § 11

General Terms and Conditions
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GENERAL PROVISIONS

§ 1

1. These General Terms and Conditions ("GTC") apply to insurance contracts concluded between Towarzystwo Ubezpieczeń na Życie "WARTA" S.A. and Policyholders through the Agent.
2. In these GTC, the terms listed below are assigned the following meanings:
   1) **Agent** – an insurance agent as defined for the purposes of the Act on insurance mediation of 22 May 2003, which is Bank Handlowy w Warszawie S.A. with its registered office in Warsaw, acting for and on behalf of the Insurer;
   2) **additional term** – a period no less than 7 days counted from the receipt by the Policyholder of a notification in which the Insurer requests the Policyholder to pay all outstanding premiums and informs the Policyholder about the consequences of failure to pay;
   3) **Critical Illness Catalog** – "WARTA Critical Illness Catalog" constituting an appendix to the GTC;
   4) **policy month** – the first policy month means the month starting on the first day of the period of cover, indicated in the policy application document; subsequent policy months mean months starting on the same date of each subsequent calendar month, and if there is no such date in a given calendar month, on the last day of that month;
   5) **critical illness** – a type of critical illness specified and defined in the critical illness catalogue, diagnosed or treated during the term of liability under the insurance contract;
   6) **policy anniversary** – the day in each subsequent year of the insurance contract corresponding to the starting date of the period of cover, indicated in the policy application document, and if there is no such day of the month corresponding to that date in a given month, the last day of that month;
   7) **premium** – an amount paid by the Policyholder on account of the cover provided under the insurance contract;
   8) **sum assured** – an amount specified in the policy application document, providing the basis for the determination of the Insurer's benefit;
   9) **benefit** – an amount to be paid by the Insurer to the Beneficiary in case of occurrence of an event covered by the insurance contract;
   10) **Policyholder** – a natural person having full capacity for legal transactions and concluding the insurance contract;
   11) **Insured –** a natural person indicated in the insurance contract, whose life or health are covered by insurance;
   12) **Insurer –** Towarzystwo Ubezpieczeń na Życie „WARTA" Spółka Akcyjna (TUnŻ "WARTA" S.A.);
   13) **insurance contract** – an insurance contract concluded on the basis of these GTC between the Insurer and the Policyholder, for the Policyholder's own account or for the account of the Insured, under which the Insurer undertakes to provide specific benefits in case of occurrence of an event covered by the insurance contract, and the Policyholder undertakes to pay the premium;
   14) **Beneficiary** – a natural person, a legal person or an organizational unit without legal personality to whom the Insurer pays the benefit in case of occurrence of an event covered by the insurance contract;
   15) **variant** – an insurance cover option selected by the Policyholder from among options varying in terms of the sum assured amounts as specified in the table in § 6 Section 2, and the premium amount, whereby the premium amount is indicated in the policy application document;
   16) **policy application document** – an insurance contract application form which is at the same time a policy document confirming the conclusion of the insurance contract;
   17) **accident** – a sudden event beyond the Insured's control and not related to the Insured's health condition caused solely by an external random cause which is the reason for the occurrence of the event covered by the Insurer's liability and has occurred during the period for which the Insurer grants insurance cover under the insurance contract;
   18) **occurrence of a critical illness** – occurrence of the following circumstances during the term of the Insurer's liability: formulation of diagnosis by a specialist doctor, provided that in the case of a critical illness in the form

of a procedure, it is understood as such procedure, and in the case of a malignant tumor it is understood as the date on which the sample is collected for the purpose of histopathological examination which confirms the presence of the tumor, in the case of loss of speech it is understood as the first day of the 12-month period of total and irreversible loss of speech as described in § 8 of the Critical Illness Catalogue.

OBJECT AND SCOPE OF INSURANCE
§ 2

1. The object of the insurance is the life and health of the Insured.
2. Under the insurance contract, the Insurer provides cover with regard to the following events:
   1) Insured's death;
   2) Insured's critical illness;
   subject to Section 8.
3. The Insurer is liable for the critical illness of the Insured provided that the critical illness occurs during the term of the Insurer's liability.
4. The Insurer's liability consists of payment of the benefit in the event of occurrence of a critical illness as provided for in GTC, in the amount of the sum assured indicated in GTC.
5. In the case of occurrence of at least two critical illnesses of the Insured of the same type during the term of the insurance contract the Insurer shall pay only one benefit for the occurrence of the first critical illness.
6. In the case of occurrence of at least two critical illnesses of the Insured of different types during the term of the insurance contract the Insurer shall not be liable for any critical illness which has a cause-and-effect relationship or are caused by the same pathogen as the critical illness for which the Insurer paid the benefit.
7. In the case of occurrence of at least two malignant tumors of the Insured of different histopathological structure and location the Insurer shall pay only one benefit for the occurrence of a critical illness of this type.
8. The events listed in Section 2 constitute an insurance package available in three variants (Variant I, Variant II, Variant III) indicated in § 6 Section 2. The insurance variants differ in terms of premium amount and sum assured for critical illness. The Insurer shall indicate one of the insurance variants covering the Insured in the policy application document. Selecting an insurance variant in the policy application document is tantamount to concluding an insurance contract with respect to events and sums assured specified for such a variant.

CONCLUSION OF THE INSURANCE CONTRACT
§ 3

1. The insurance contract is concluded for five years and is renewed for another five-year period unless the Insurer submits to the Policyholder at least 30 days or the Policyholder submits to the Insurer at least 14 days before the fifth policy anniversary a notice in writing regarding their lack of consent to renew the insurance contract for another five-year period of cover. The insurance contract may be renewed for any number of five-year periods, subject to the above rule of submitting a notice before each policy anniversary ending the given five-year period of cover, as long as the Insured is less than 55 years old on the day of such insurance contract renewal.
2. The insurance may only cover a natural person who is 18 years of age and less than 55 years of age on the day of the insurance contract.
3. The Insured may be covered under only one insurance contract concluded under these GTC at the same time.
4. The insurance contract is concluded on the basis of a policy application document signed by the Policyholder and the Insured and addressed to the Insurer on the form provided by the Insurer.
5. If the policy application document is completed wrongly or incomplete, the Insurer will request the Policyholder to correct the form or provide the missing items or, alternatively, to submit a new application within 14 days from the date of receiving a written request by the Policyholder.
6. The variant may be changed only by concluding a new insurance contract, which is possible only after terminating the previous contract.
7. The Insurer may conclude or refuse to conclude the insurance contract, and in the case of insurance contract renewal the Insurer may propose new conditions of insurance.
8. In the case of renewed insurance contract conclusion or insurance contract renewal the Insurer may request the necessary documents concerning the Insured's health status required to perform insurance risk assessment or may refer the Insured for medical examination or diagnostic tests. The cost of such examination or tests shall be covered by the Insurer.
9. The Policyholder may withdraw from the insurance contract or terminate it on the terms specified in § 5.

DURATION OF THE INSURER'S LIABILITY
§ 4.

1. The liability of the Insurer for events described in § 2 Section 2 commences on the date indicated in the policy application document as the beginning of cover, provided that the premium is paid on the day of signing the policy application document, in such amount as stipulated in the policy application document.
   If the premium is not paid in the above time limit, but is credited to the Insurer's account before expiry of the time limit stipulated in § 6 Section 9, the Insurer's liability commences on the day following the payment of the first premium in such amount as stipulated in the policy application document.

2. Within 90 days of the day indicated in the policy application document as the beginning of cover and not earlier than starting from the day following the date of payment of the first premium, the Insurer provides cover only against the critical illnesses stipulated in § 8-10 of the Critical Illness Catalogue, i.e. loss of speech, loss of sight, loss of hearing, suffered as result of an accident.
3. The liability of the Insurer ends on the date of termination of the insurance contract.

TERMINATION OF THE INSURANCE CONTRACT
§ 5

1. The Policyholder may withdraw from the insurance contract within 30 days of its conclusion. In the case of withdrawal, the Policyholder is entitled to a refund of the full premium paid.
2. The Policyholder may terminate the insurance contract at any time during its term, effective at the end of the policy month in which the Insurer or the Agent receives the termination notice.
3. Termination of the insurance contract does not release the Policyholder from the obligation to pay the premium due for the duration of cover provided by the Insurer.
4. The insurance contract is terminated and the cover expires due to:
   1) withdrawal from the insurance contract by the Policyholder – as of the date of submitting the relevant withdrawal notice to the Insurer or Agent;
   2) termination of the insurance contract by the Policyholder – as of the date of expiry of the period of notice indicated in Section 2;
   3) the Policyholder's failure to pay the premium as provided for in § 6 Section 10 – as of the end of the last day of the additional term;
   4) the Insured's death – on the day of the Insured's death;
   5) expiry of the contract term if one of the parties submits a notice regarding lack of consent to renew the contract, in accordance with the provisions of § 3 Section 1;
   6) the Insured's turning 60 years of age – on the first policy anniversary after the day of the Insured's 60th birthday.

SUM ASSURED AND PREMIUM
§ 6

1. The sum assured on which the benefit amount is based is fixed during the period of cover and set for the given event as a specific amount in the policy application document depending on the insurance variant selected by the Policyholder and the Policyholder's age on the date of the insurance contract or on the date of insurance contract renewal as set forth in § 3 Section 1, in accordance with the table in Section 2.
2. The scope of events covered by the Insurer's liability in individual variants and the sum assured amount referred to in Section 1 for events indicated in § 2 Section 2 in each variant are provided in the following table:

Variant		**Variant I**		**Variant II**		**Variant III**	
Age / **Sum assured**		Death	Critical illness	Death	Critical illness	Death	Critical illness
Insured's age	18 – 35	PLN 1,000	PLN 100,000	PLN 1,000	PLN 150,000	PLN 1,000	PLN 200,000
	36 – 45	PLN 1,000	PLN 50,000	PLN 1,000	PLN 75,000	PLN 1,000	PLN 100,000
	46 – 55	PLN 1,000	PLN 20,000	PLN 1,000	PLN 30,000	PLN 1,000	PLN 40,000

3. In exchange for the conclusion of the insurance contract the Policyholder must pay a premium in such amount as stipulated in the policy application document, subject to § 5 Section 1.
4. The Policyholder is obliged to pay the premium in advance, on a monthly basis, for each policy month.
5. The Policyholder is obliged to pay the first premium within one day of signing the policy application document, subject to Section 7.
6. All further premiums must be paid by the Policyholder by the first day of the period for which the premium is due.
7. The date of premium payment shall be the day on which the premium amount is credited to the bank account designated by the Insurer to the Policyholder, in such amount as stipulated in the insurance contract.
8. The payment date of the premium is observed if the entire amount due of the premium is paid before that date.
9. Failure to pay the first premium as stipulated in the policy application document within 30 days of concluding the insurance contract means that cover is not commenced and the insurance contract is deemed as terminated by the Policyholder upon expiry of the above 30-day period.
10. If the Policyholder does not pay a subsequent premium within the time limit specified in Section 6, the Insurer shall request the Policyholder to pay the outstanding premium by the expiry of an additional term set by the

Insurer and shall notify the Policyholder of the effects of failing to pay the premium within such an additional term.

11. The premium amount is set on the basis of the scope of cover and value of the sum assured.
12. The amounts of the premium and of the sum assured are set for the five-year term of the insurance contract.
13. If the insurance contract is renewed for another five-year period of cover, the premium and the sum assured are to change in accordance with § 3 Section 7, the Insurer shall, 30 days prior to the policy anniversary after which the contract is to be renewed, send the Policyholder a proposal of the insurance contract renewal for another five-year period, indicating the new amounts of the premium and the sum assured applicable to the next five-year period of insurance.
14. If the Policyholder delivers to the Insurer a statement of lack of consent to the new conditions of insurance as referred to in Section 13 within 14 days prior to the policy anniversary after which the contract is to be renewed, such statement is considered a statement of lack of consent to insurance contract renewal and the insurance contract is terminated upon expiry of the period of cover.
15. The change of conditions as referred to in section 13 is confirmed in writing.

CALCULATION AND PAYMENT OF INDEMNITY
§ 7

1. Upon the Insured's death, the Insurer shall pay the Beneficiary a benefit equal to the sum assured applicable as of the day of the Insured's death.
2. In the case of critical illness of the Insured, the Insurer shall pay the Insured a benefit in the amount of the sum assured for the Insured's critical illness applicable on the day of occurrence of such illness, subject to § 2 Section 5-7.

§ 8

1. The death benefits are paid on the basis of a benefit payment application/notification of the event, to which the Beneficiary has to attach documents indicated by the Insurer as required to determine the legitimacy and amount of the benefit.
2. The critical illness benefit is paid on the basis of a benefit payment application submitted to the Insurer, to which the Insured has to attach documents indicated by the Insurer, required to determine the legitimacy and amount of the benefit.
3. The documents referred to in Section 1 and Section 2 are, depending on the insured event:
   1) in the case of death:
      a) abridged copy of the Insured's death certificate;
      b) death cause certificate (statistical record for the death card);
      c) ID document of the Beneficiary;
      d) medical records documenting the treatment of the Insured (e.g. medical case record, examination results, hospital discharge summaries);
      e) if the insured event occurred as a result of an accident, it is necessary to submit additional documents confirming the occurrence of the event and describing the circumstances of the accident;
      f) other documents indicated by the Insurer as required to determine the legitimacy and amount of the benefit.
   2) in the case of critical illness:
      a) ID document of the Insured for inspection;
      b) medical documentation confirming the critical illness of a given type (e.g. result of histopathological examination, documentation confirming myocardial infarction, stroke);
      c) medical records documenting the treatment of the Insured (e.g. medical case record, examination results, hospital discharge summaries);
   3) other documents indicated by the Insurer as required to determine the legitimacy and amount of the benefit.
4. A benefit for critical illness resulting from an accident can be determined by the Insurer, based on the documentation provided, after a causal relationship is found between the accident and the critical illness.
5. The persons entitled to receive a death benefit are persons properly indicated by the Insured as the Beneficiaries, and if no such beneficiaries are identified, the persons specified in § 10 Section 3.
6. The Insured is the person entitled to receive the critical illness benefit.
7. Where any of the documents required to establish the benefit are in a language other than Polish, the Insurer may demand that the Beneficiary submit such documents together with their certified translation into Polish.
8. Within 7 days of receipt of the notification of the chance event covered, the Insurer notifies the Policyholder or the Insured, if they are not the parties making the notification, and proceeds with the investigation of the facts of the event and legitimacy of the claims and with calculation of the benefit amount, and informs the claimant in writing or otherwise in a manner agreed on by that party what documents are required in order to

determine the Insurer's liability, if necessary in order to proceed. For insurance contracts concluded for a third-party account, the Insured or the Insured's heir may also make a notification of the chance event.

9. The Insurer shall pay the benefit within 30 days of the date of receipt of the notification of the event.
10. If clarification of the circumstances necessary to establish the benefit entitlement or benefit amount proves impossible within the 30 days stipulated in Section 9, the insurance benefit will be paid within 14 days after the day on which such circumstances are duly clarified. However, any indisputable part of the benefit shall be paid out by the Insurer within 30 days of the date of receiving the notification of the event.
11. Where the Insurer does not make any benefit payment within the timeframes set in Sections 9-10, the Insurer shall notify:
    1) the claimant; and
    2) for insurance contracts concluded for a third-party account, the Insured if different from the claimant;

    why all or a part of those claims cannot be satisfied, and shall pay an indisputable part of the benefit to the Beneficiary.
12. If the benefit does not apply or applies in a different amount than that stated in the claim, the Insurer shall inform in writing
    1) the claimant; and
    2) for insurance contracts concluded for a third-party account, the Insured if different from the claimant;

    - referring to the circumstances and the legal base supporting the refusal to pay all or a part of the benefit. Such communication shall include a note advising of the possibility to assert claims in court.
13. The date of crediting the bank account of the party who is to receive the benefit with the benefit amount due or, in the case of a money order, the day on which the party who is to receive the benefit receives the benefit amount due will be deemed to be the date of benefit payment.
14. If any information is concealed or false information is provided to the Insurer in the process of concluding the insurance contract, the Insurer will be released from liability as set forth in the provisions of the Polish Civil Code.

PERSONS ENTITLED TO THE BENEFIT

§ 9

1. The Insured may designate a Beneficiary entitled to receive the death benefit from the Insured whether in the process of concluding the insurance contract or at any time thereafter.
2. The Insured may change or revoke the designation referred to in Section 1 at any time during the term of the insurance contract.
3. The application for changing the Beneficiary shall be submitted by the Insured in written form.
4. The Insurer is bound by any change so requested starting from the date of submitting the application for change of the Beneficiary to the Insurer.
5. If the Policyholder is indicated as the Beneficiary entitled to receive the benefit, the Insured or the Insured's heirs are entitled to claim the benefit directly from the Insurer provided that the Policyholder submits a statement on waiver of the right to the benefit from the Insurer.

§ 10

1. If the Insured designates more than one Beneficiary to receive the benefit, the benefit is paid to each Beneficiary as a predetermined percentage of the benefit amount; unless the Insured determines the respective shares of Beneficiaries in the benefit, each Beneficiary is deemed to have an equal share.
2. If the Beneficiary contributes to the Insured's death by willful misconduct or dies before the Insured's death, such designation becomes void.
3. If at the time of the Insured's death there is no Beneficiary, the benefit will be transferred to family members of the deceased, in the following order of precedence:
    1) to the spouse;
    2) if there is no spouse – to the children, in equal parts;
    3) if there are no spouse or children – to the parents, in equal parts;
    4) if there are no such persons as listed in Items 1)–3) above – to other appointed heirs of the Insured, in equal parts.

EXCLUSIONS AND LIMITATIONS OF THE INSURER'S LIABILITY

§ 11

1. The liability of the Insurer on account of the Insured's death does not cover events arising from:

1) self-mutilation or mutilation at own demand, suicide or attempted suicide by the Insured within 2 years of commencement of the period of cover;
2) acts of war, martial law or active engagement of the Insured in riots, social unrest, acts of terror;
3) the Insured's participation in medical treatment, therapy or medical procedures performed without supervision of physicians or other authorized persons;
4) nuclear, chemical, biological contamination (irrespective of its causes) or radiation.

2. The liability of the Insurer on account of critical illness does not cover the events listed in Section 1 Item 2)-4) and events arising from:
   1) self-mutilation or mutilation at own demand or attempted suicide by the Insured;
   2) HIV infection;
   3) poisoning or taking actions by the Insured under the influence of alcohol, drugs or toxic substances and as result of illnesses caused by alcohol, drugs or toxic substances, except where these substances are taken in accordance with the doctor's order;
   4) pursuit of high-risk sports by the Insured, i.e.: scuba diving, alpine climbing, rock climbing, mountaineering, potholing, ballooning, hang gliding, gliding, aviation (sports, military, professional or amateur aircraft or helicopter piloting), paragliding, paramotoring, parachuting, car or motorcycle rallying, go karting, quad biking, powerboating, martial arts, bungee jumping;
   5) driving of a road vehicle, marine vessel or aircraft by the Insured:
      a) without the license to operate the given vehicle or vessel or aircraft as required by law, or
      b) without the technical inspection certificate for the given vehicle or vessel or aircraft as required by law which confirms their road-, sea- or airworthiness,

      unless the circumstances listed under letters a)–b) did not contribute to the occurrence of the insured event;
   6) commission or attempted commission of a willful crime by the Insured or another person aided and abetted or incited by the Insured;
   7) the Insured's being diagnosed with mental illness or mental disturbances, nervous breakdowns or addictions as defined in the International Statistical Classification of Diseases and Related Health Problems ICD-10 (F00-F99).

FINAL PROVISIONS
§ 12

1. All notices and representations in connection with the insurance contract should be made in writing, subject to § 13 Section 2.
2. The Policyholder, the Insured and the Insurer shall notify each other of each change of address or other details necessary for communication in respect of the performance of the insurance contract.
3. If the surname or first name of the Insured or the Beneficiary is changed after concluding the insurance contract, the applicant requesting benefit payment must produce documents supporting the applicant's entitlement which are consistent with the data held by the Insurer.
4. The date of submitting a representation concerning the insurance contract or notification of an event/benefit payment application to the Insurer (or submission to the Insurer or receipt of a representation concerning the insurance contract or notification/application by the Insurer, as the case may be) shall be understood as the date of the submission of such a representation or notification/application to the Insurer or the Agent.
5. Complaints, including appeals and grievances, can be submitted by the Policyholder, the Insured or the Beneficiary under the insurance contract to the Insurer:
   1) in writing to the following address: skr. poczt. 1013, 00-950 Warszawa 1;
   2) in electronic form using the form available on www.warta.pl/reklamacje;
   3) by telephone by dialing 502 308 308;
   4) at any office of the Insurer in a written notice delivered in person or orally for the record;
   5) to the Agent in one of the following forms:
      a) written form – submitted personally at a bank branch during the working hours of the branch or sent to the following address: Bank Handlowy w Warszawie S.A., Client Complaint and Inquiry Department, ul. Goleszowska 6, 01-249 Warsaw;
      b) oral form – made by phone or personally for the record during the client's visit at a bank branch;
      c) electronic form – sent to the email address of the Bank, via Citibank Online after logging in using the tab "Contact the bank" and on the website www.citibank.pl, using the complaint form.

      The up-to-date contact details for submitting complaints are available on the Bank's website (www.citibank.pl).

6. In the case that the information provided in Section 5 Items 1)–3) changes, the Insurer will notify the Policyholder, the Insured and the Beneficiary of each such change in writing. Such change does not represent an amendment to the insurance contract.
7. The Insurer examines the complaint, appeal or grievance within 30 days as of receipt and provides a response in writing by mail or e-mail at the request of the person submitting the complaint, appeal or grievance. In particularly complex cases, where the complaint cannot be examined and answered within the above time limit, the deadline for providing a response may be extended to 60 days, of which the person submitting the complaint, appeal or grievance is previously notified.
8. The Insurer's organizational unit designated by the Management Board of TUnŻ "WARTA" S.A. shall be the competent body for examination of the complaint, appeal or grievance.
9. The institution authorized to handle alternative dispute resolution processes is:
   1) the Arbitration Court at the Polish Financial Supervision Authority (www.knf.gov.pl/regulacje/Sad_Polubowny/index.jsp);
   2) the Financial Ombudsman (www.rf.gov.pl).
10. Detailed information on the procedure for submitting and examining complaints, appeals or grievances is available on www.warta.pl.
11. Irrespective of the provisions of these GTC the Insurer performs its informational duties within the scope resulting from applicable provisions of law.

§ 13

1. Provisions that are additional to or different from these GTI may be incorporated into the insurance contract in agreement with the Policyholder. Any amendments to the insurance contract must be made in writing to be valid.
2. If the Insurer and the Policyholder so permit, notices or declarations of intent may be made in a form other than in writing, except where the obligation to submit notices or declarations in writing is provided for by law or GTC provisions.
3. The Insurer informs the Policyholder in writing about changes in the insurance contract or changes in the governing law applicable to the concluded contract, following the procedure and requirements specified in the Act on insurance and reinsurance activities.
4. The Policyholder is obliged to provide the following information to the Insured in writing:
   1) information indicated in Section 3 before the Policyholder agrees to a change in the provisions of the contract or the governing law applicable to the insurance contract,
   2) information concerning the amount of benefits immediately after the Insurer provides such information to the Policyholder.

   Irrespective of the above, the Insurer is obliged to provide this information to the Insured at the Insured's request.
5. Claims under the insurance contract are subject to a statute of limitations of 3 years.

§ 14

1. Any matters not regulated in these GTC are governed by the provisions of the Civil Code, the Act on insurance and reinsurance activities and other applicable provisions of law as well as the relevant provisions of the tax laws.

2. The taxation of the Insurer's benefits is governed by the following laws:
   - Personal Income Tax Act (consolidated text, Journal of Laws Dz.U. 2016, Item 2032, as amended),
   - Corporate Income Tax Act (consolidated text, Journal of Laws Dz.U. 2016, Item 1888, as amended).
3. The benefits paid by the Insurer are not subject to the Act on Inheritance and Donations (consolidated text, Journal of Laws [Dz.U.] 2016 Item 205, as amended) in conjunction with Article 831 § 3 of the Civil Code Act (consolidated text, Journal of Laws [Dz.U.] 2016 Item 380, as amended).
4. An action for claims under the insurance contract may be instituted on the basis of provisions on general jurisdiction or before the court competent for:
   1) the place of residence or registered address of the Policyholder, the Insured or the Beneficiary; or
   2) the place of residence of the heir of the Insured or Beneficiary.
5. A report on the solvency and financial condition of the Insurer is published on www.warta.pl.
6. The insurance contracts concluded under these GTC are governed by the Polish law.

§ 15

These GTC were approved by resolution No. 131/2017 of the Management Board of TUnŻ "WARTA" S.A. and brought into effect on 30 June 2017.

Vice President of the Management Board
TUnŻ WARTA S.A.
Paweł Bednarek

President of the Management Board
TUnŻ WARTA S.A.
Jarosław Parkot

Appendix to the General Terms and Conditions of "Individual WARTA Your Health Plus Life Insurance"

WARTA CRITICAL ILLNESS CATALOGUE

§ 1

This catalogue specifies the following types of critical illness:
1) malignant tumor (cancer);
2) myocardial infarction;
3) stroke;
4) surgical treatment of coronary artery disease (by-pass);
5) renal failure;
6) organ transplants;
7) loss of speech;
8) loss of sight;
9) loss of hearing.

MALIGNANT TUMOR (CANCER)

§ 2

Malignant tumors (cancers) are malignant tumors (cancers) characterized by uncontrolled growth and spread of neoplastic cells, resulting in infiltrates and destruction of normal tissues of the body. Their diagnosis must be confirmed by a histopathological examination. The insurance cover applies also to cases of leukemia, malignant lymphoma (including lymphoma of the skin), Hodgkin lymphoma, malignant neoplasm of bone marrow and sarcoma.
The insurance does not cover:
1) non-invasive carcinoma, carcinoma in situ (pre-invasive), dysplasia, borderline tumors, tumors of low malignant potential and any precancerous lesions,
2) prostatic carcinoma, stage T1 in the TNM system (including T1a, T1b, T1c) or a corresponding stage determined according to another classification system,
3) any neoplasm of the skin except for malignant melanoma that has spread beyond the epidermis,
4) papillary thyroid carcinoma limited to the thyroid, stage T1 in the TNM system (including T1a, T1b),
) chronic lymphocytic leukemia, Rai stage <III,
6) early stage of carcinoma of the bladder classified as T1N0M0 (TNM system) in a histopathological examination,
7) any tumors with concomitant HIV infection.

MYOCARDIAL INFARCTION

§ 3

Myocardial infarction, or heart attack, means necrosis of a portion of the cardiac muscle due to a sudden interruption of blood supply to a given area of the cardiac muscle.
Diagnosis must be based on finding an increase or decrease in the level of cardiac biomarkers (troponin I, troponin T or CK-MB) in the blood, with at least one value exceeding the 99th percentile of the reference range for a given laboratory method, with the presence of the following clinical markers of myocardial ischemia:
1) typical clinical manifestations of myocardial infarction,
2) one of the following ECG findings indicating acute myocardial ischemia: newly developed ST-T segment elevation or depression, T-wave inversion, new pathological Q waves or newly developed left bundle branch block.
The insurance cover does not apply to other acute coronary syndromes.

STROKE

§ 4

Stroke is defined as necrosis of the brain tissue caused by an interruption of blood supply to a portion of the brain or by hemorrhage into the brain tissue, in the presence of all of the following:
1) development of new clinical neurological symptoms consistent with stroke,
2) presence of objective neurological deficits found on neurological examination for at least 60 days after stroke diagnosis,
3) presence of new lesions typical of stroke seen in computed tomography or nuclear magnetic resonance images (if these scans were performed).

The insurance does not cover:
1) any episodes of transient brain ischemia (TIA, RIND),
2) cerebral infarction or intracranial hemorrhage caused by external trauma,
3) hemorrhage secondary to existing post-stroke focal lesions,
4) any brain lesions that may be identified with imaging studies without concomitant
fixed clinical symptoms reflecting these lesions,
5) migration-induced symptoms,
6) vascular disease affecting the vision, optic nerve or body balance,
7) ischemia caused by vertebrobasilar insufficiency (symptoms of vertebrobasilar insufficiency).

SURGICAL TREATMENT OF CORONARY ARTERY DISEASE (BY-PASS)

§ 5

Surgical treatment of coronary artery disease means open heart surgery consisting in coronary artery bypass grafting due to narrowing or occlusion of two or more coronary arteries, except percutaneous balloon angioplasty, laser angioplasty and other non-surgical techniques.
The need for such a procedure must be confirmed with coronarography.

RENAL FAILURE

§ 6

Renal failure is defined as end-stage renal disease with irreversible bilateral renal function impairment that constitutes an absolute indication for chronic dialysis therapy or kidney transplantation.
The insurance does not cover: acute reversible renal failure that requires temporary dialysis therapy and unilateral renal failure.

ORGAN TRANSPLANTS

§ 7

Organ transplants mean cases where the insured person receives a transplant of one of the following organs: heart, lung, liver, kidney, pancreas.
The transplantation procedure must be medically justified and follow a confirmed diagnosis of irreversible end-stage failure of the relevant organ.

LOSS OF SPEECH

§ 8

Loss of speech means total and irreversible loss of the ability to speak that persists continuously for at least 12 months. The diagnosis must be confirmed by an ENT specialist based on a diagnosed vocal fold disease or injury. The insurance does not cover any cases of loss of speech caused by mental disorders. The insurance does not cover cases of loss of speech that can be corrected with medical treatment.

LOSS OF SIGHT

§ 9

Loss of sight means total and irreversible loss of sight in both eyes caused by sudden illness or injury. The diagnosis must be confirmed by an ophthalmologist. The insurance does not cover cases of loss of sight that can be corrected with medical treatment.

LOSS OF HEARING

§ 10

Loss of hearing means total and irreversible loss of hearing in both ears caused by sudden illness or injury. The diagnosis must be based on an audiometric test and confirmed by an ENT doctor. The insurance does not cover cases of loss of hearing that can be corrected with medical treatment.

§ 11

This WARTA Critical Illness Catalogue was approved by resolution No. 131/2017 of the Management Board of TUnŻ "WARTA" S.A. and brought into effect on 30 June 2017.

Vice President of the Management Board

President of the Management Board

TUnŻ WARTA S.A.
Paweł Bednarek

TUnŻ WARTA S.A.
Jarosław Parkot