РОСГОССТРАХ

APPROVED BY

Order of Rosgosstrakh JSC

No. 15 dated March 17, 2015

PASSENGERS INSURANCE RULES

No. 215

(as amended by the Order of PJSC IC "Rosgosstrakh" No. 357 dated May 30, 2016).

Moscow, 2016

1. GENERAL PROVISIONS

1.1. These Passenger Insurance Rules (hereinafter - the Rules) have been developed in accordance with the Civil Code of the Russian Federation, the Law of the Russian Federation “On the Organization of Insurance Business in the Russian Federation”, and other regulatory legal acts.

According to the legislation of the Russian Federation and on the basis of these Rules, the PJSC IC "Rosgosstrakh" (hereinafter - the Insurer) concludes voluntary railway passengers Accidents Insurance contracts with capable Individual, legal entities and individual entrepreneurs (hereinafter - the Policyholders) for the amount of payment (insurance premium) stipulated by the insurance contract / insurance policy (hereinafter - the Insurance contract).

1.2. When entering into an Insurance contract under the terms of these Rules, the Insurance contract shall explicitly specify the application of the Rules. Delivery of the Rules to the Policyholder must be verified by an entry in the Insurance contract.

When entering into an Insurance contract the parties may agree to change or exclude certain provisions of these Rules from the terms of the Insurance contract, provided that such changes or exclusions do not contradict the legislation of the Russian Federation and these Rules.

1.3. The Insurer shall be entitled to develop various insurance programs for a separate Insurance contract or separate groups of Insurance contracts concluded on the basis of these Rules, to the extent that this does not contradict the legislation of the Russian Federation and these Rules, and assign marketing names to them.

1.4. The Insurer shall not disclose information about the Policyholder, the Insured person, the Beneficiary, their state of health and property status, received as a result of his professional activity, unless otherwise provided by the legislation of the Russian Federation.

1.5. In accordance with the legislation of the Russian Federation, the Insurance benefit shall be paid to the Beneficiary or another person entitled to receive Insurance benefit, regardless of the amounts due to them under other Insurance contracts, compulsory social insurance, social security and compensation for harm.

1.6. Basic terms used in these Rules:

1.6.1. *Accident* - an actual event that has occurred during the validity of the Insurance contract, regardless of the will of the Insured person and/or the Policyholder, and/or the Beneficiary, a sudden, transient, unforeseen event resulting in a traumatic injury, acute poisoning (other than food toxic infection, poisoning by alcohol-containing, narcotic, psychotropic substances), not being a consequence of a disease and resulting in temporary or permanent loss of general working capability or death of the Insured person in the railway passenger transport or in the territory of the station, railway station, stopping point, passenger platform and other places designed to serve passengers.

Under these Rules, an acute or chronic disease and its complications (both previously diagnosed and first diagnosed), caused by exposure to external factors, in particular, bronchial asthma, acute respiratory disease, any manifestations of allergic reactions, myocardial infarction, stroke, aneurysms, tumors, functional insufficiency of organs, congenital organ anomalies and others, as well as infectious diseases, including accompanied by intoxication shall not be considered as an accident.

1.6.2 *Temporary loss of working capability* — incapability to work that occurred during the validity period of the Insurance contract as a result of an accident that occurred during the validity period of the Insurance contract, accompanied by the inability to perform professional duties during the period necessary for the continuous treatment of the consequences of the accident.

For non-working Insured Persons, including children under 18 and retirees, the temporary disability refers to a temporary acute impairment of health within a certain limited uninterrupted period of time, as a result of an accident.

Uninterrupted period of time (continuous treatment) includes only the treatment prescribed by a qualified doctor, that according to medical science, corresponds to the nature of the injury sustained by the Insured person, with periodic (at least once every 10 days) monitoring of its effectiveness (in case of appointment or visit by a doctor).

Periodic preventive measures (such as vaccination against tetanus, rabies, etc.) shall not be considered treatment of injuries. The time of their conduct shall not be taken into account in determining the period of continuous treatment.

1.6.3 *Permanent loss of general working capability* of the Insured person - social insufficiency of the Insured person due to impaired health with persistent disorder of body functions, leading to disability and the need for social protection as a result of an accident that occurred within the period of validity of the Insurance contract.

Disability groups correspond to the groups established by the Medical and Social expertise Bureau (hereinafter- the MSE Bureau) to characterize the degree of disability and the requirements of care, prescriptions and restrictions of a medical nature.

1.6.4 *Passenger* - an Individual who has concluded a contract of passenger transportation and who is travelling by rail with a valid travel document.

2. PARTICIPANTES OF THE INSURANCE

2.1. Participants of the insurance are the Insurer, Policyholder, the Insured person, and the Beneficiary.

2.2. Insurer **-** Public Joint-Stock Company “Rosgosstrakh” Insurance Company (PJSC IC Rosgosstrakh), established in accordance with the legislation of the Russian Federation to carry out insurance activities and licensed to carry out the relevant type of insurance activities in accordance with the law.

2.3. **Policyholder** – a capable Individual, legal entity or individual entrepreneur who has concluded an Insurance contract with the Insurer in its own favor or in favor of third parties (Insured persons).

2.4. **Insured person -** an Individual traveling by rail as a passenger, in respect of whose life and health an Insurance contract has been concluded.

The Policyholder may replace the Insured Person specified in the Insurance contract by another person only with the consent of the Insured Person and the Insurer.

2.5. **Beneficiary** – an Individual in whose favor the Insurance contract is concluded, and who is entitled to receive the Insurance benefit.

The Policyholder, with the written consent of the Insured Person, has the right to designate any person as a recipient of the Insurance benefit (hereinafter - the Beneficiary).

If the Beneficiary is not appointed, the Insured person is recognized as a Beneficiary, and in case of his death, his heir (heirs) shall be recognized as the Beneficiary.

2.5.1. If the recipient of the Insurance benefit is:

a) under 14 y.o., then his parents, adoptive parents or Trusties shall be entitled to receive the Insurance benefit;

b) from 14 to 18 years, then the right to receive the Insurance benefit belongs to the recipient;

c) a person declared incapable, then the right to receive the Insurance benefit passes to his Trustee;

d) a person whose legal capability is limited, then the right to receive Insurance benefit remains with the recipient only with the written consent of his Trustee.

When the recipient of the Insurance benefit is a person specified in paragraphs a), c), d) of this clause, the Insurance benefit shall be paid to the specified legal representatives of the recipient only on the basis of the documents confirming the relevant right.

2.6. During the validity period of the Insurance contract, with the written consent of the Insured person, the Policyholder may replace the Beneficiary named in the Insurance contract with another person, notifying the Insurer in writing.

The Beneficiary may not be replaced by another person after he has fulfilled any of the obligations under the Insurance contract or has submitted a claim for Insurance benefit payment to the Insurer.

3. SUBJECT OF INSURANCE:

The subject of insurance are the property interests pertaining to the injuries of the Insured person, as well as his death as a result of an accident.

4. INSURED RISKS. INSURED EVENTS

4.1. The Insured risk is a prospected event with characteristics of probability and randomness, specified by the insurance contract. The occurred event, specified as an Insured risk, is recognized as an Insured event.

The Insured event is the event specified by the Insurance contract, the onset of which induces the Insurer's obligation to effect Insurance benefit payment to the Insured person or the Beneficiary.

4.2. The Insured events under these Rules, subject to the exclusions set out in clause 4.6. of the Rules on events that are not accepted as Insured events, include the following events, the onset of which induces the Insurer's obligation to effect Insurance benefit payment to the Insured person (Beneficiary):

4.2.1 *"Temporary loss of general working capability as a result of an accident"* - temporary loss of general working capability by the Insured person or temporary acute health disorder as a result of an accident that occurred within the validity period of the Insurance contract during the trip of the Insured person as a passenger on the railway transport, with a causal relationship between the accident and the temporary loss of the Insured person's general working capability or the temporary acute health disorder of the Insured person.

4.2.2 *"Permanent loss of general working capability (disability) as a result of an accident"* - assignment of the 1st, 2nd or 3rd group of disability or the "disabled child" category to the Insured person within 12 months (unless otherwise provided by the Insurance contract) from the date of an accident that occurred within the validity period of the Insurance contract during the trip of the Insured person as a passenger on the railway transport, with a causal relationship between the accident and the and the assignment of disability to the Insured person;

4.2.3 *"Death as a result of an accident"* - the death of the Insured Person that occurred within 12 months (unless otherwise provided by the Insurance contract) from the date of an accident that occurred within the validity period of the Insurance contract during the trip of the Insured person as a passenger on the railway transport, with a causal relationship between the accident and the death of the Insured person.

4.3. Under these Rules, the Insured events, with the exclusion of cases stipulated by clause 4.6. of these Rules, are the events stipulated by clause 4.2 of these Rules, resulting from an accident (clause 1.6.1. of these Rules) that occurred with the Insured person during the validity period of the Insurance contract and

confirmed by documents of the relevant authorities, issued in the manner prescribed by law and by these Rules.

4.4. Under these Rules, the Insurance contract is concluded for the period of one railway trip of the Insured person (Insurance contract validity period).

4.5. Unless otherwise explicitly provided for in the Insurance contract, the trip period starts from the moment of the announcement of boarding the vehicle, but not earlier than 30 minutes before departure (at an intermediate station on the route of the vehicle, from the moment of announcement of the arrival of the vehicle at the station / railway station) and ends at the moment when the Insured person leaves the destination point (station / railway station), provided that
no more than one hour has passed from the moment of arrival of the vehicle till the moment when the Insured person leaves the destination point (station / railway station).

4.6. Under the Insurance contract in accordance with these Rules the following events that occurred with the Insured person during the trip are not covered by the insurance (excluded from the Insured risk definition):

4.6.1. suicides or attempted suicides of the Insured person, except for cases when the Insured person was brought to suicide or attempted suicide by the illegal actions of third parties;

4.6.2. alcohol intoxication of the Insured person, or toxic or narcotic intoxication, or poisoning of the Insured person as a result of consumption of alcohol-containing, narcotic, toxic and psychotropic substances without the prescription of the doctor (or by the prescription of the doctor, but with violation of the prescribed dosage), except for cases when the Insured person was brought to such a state as a result of illegal actions of third parties;

4.6.3. commission by the Insured person of an intentional crime that is directly causally related to the accident;

4.6.4. failure of the Insured to comply with the requirements of the trainmaster or other authorized officials;

4.6.5. violation by the Insured person of the railway transport travel rules or other event that is not directly related to the trip or passenger service, before or after the announcement of boarding the vehicle or leaving it at the destination;

4.6.6. diseases (acute, subacute, chronic (including mental), infectious, including those accompanied by intoxication) and post-traumatic conditions (including post-traumatic arthritis/arthrosis, post-traumatic contracture, habitual dislocation, pathological fracture, damage to the implants of the capsule-ligamentous apparatus, post-traumatic encephalopathy, post-traumatic stress disorder, etc.).

4.6.7. intentional causing and/or attempting to cause self-inflicted injuries by the Insured person, regardless of his mental state, or intentional causing the injuries to the Insured person with his consent by any other person, regardless of the mental state of the Insured person.

4.7. The Insurer shall be exempt from the insurance benefit payment obligation, if the Insured event occurred due to the intent of the Policyholder, the Insured person or the Beneficiary.

4.8. Unless otherwise specified by the Insurance contract, the Insurer shall be exempt from the payment of Insurance indemnity, if the insured event occurred due to:

4.8.1. impact of a nuclear explosion, radiation or radioactive contamination;

4.8.2. military operations, as well as maneuvers or other military activities;

4.8.3. civil war, popular unrest of any kind or strikes.

4.9. The Insurer shall have the right to refuse to pay the Insurance benefit if the Policyholder (the Insured person, his legal representative or Beneficiary) has not notified the Insurer (or his representative) of occurrence of the Insured event (clause 10.1 of these Rules), unless it is proved that the Insurer has timely learned of the

occurrence of the Insured event, or that the lack of information about the event could not affect Insurer's obligation to pay the Insurance benefit.

The Insurer's refusal to pay the Insurance benefit may be appealed by the Policyholder (Insured person, his legal representative or Beneficiary) in the way prescribed by the legislation of the Russian Federation and by the Insurance contract.

5. SUM INSURED

5.1. *Sum insured* – the sum of money stipulated in the Insurance contract and used to determine the amount of the Insurance premium (Insurance contributions) and the amount of Insurance benefit in the case of Insured event.

5.2. The sum insured shall be determined by agreement of the parties and specified in the Insurance contract.

The sum insured shall be established as a single sum for all Insured risks provided for in the Insurance contract.

5.3. The sum insured shall be established for each Insured person (individual sum insured).

The total amount of insurance benefit for all Insured events that occurred with the Insured person during the term of the Insurance contract cannot exceed the amount of the individual sum insured.

5.4. The sum insured shall be set in Russian rubles. By agreement of the parties the sum insured in the Insurance contract could be specified in a foreign currency equivalent to the corresponding amount in rubles (hereinafter - the insurance with a currency equivalent).

6. INSURANCE PREMIUM

6.1. *Insurance premium (insurance contribution)* – a payment for insurance, which the Policyholder is obliged to pay to the Insurer in the manner and terms established by the Insurance contract.

6.2. *Insurance rate* - the insurance premium rate per unit of the sum insured, with consideration of the insurance object, the nature of the Insured risk, and other insurance terms.

6.3. The amount of the Insurance premium shall be determined by the Insurer on the basis of the sum insured and the Insurance rate.

6.4. In determining the amount of Insurance premium, depending on the route, duration of the trip, etc., the Insurer has the right to establish either increasing or decreasing coefficients (correction coefficients) to the basic insurance rates.

6.5. The Insurance premium under the Insurance contract shall be paid by the Policyholder in a lump sum before the trip.

6.6. Procedure for the payment of Insurance premium:

6.6.1. unless otherwise specified by the parties in the insurance contract, the Insurance premium under the Insurance contract shall be paid by the Policyholder to the Insurer in cash or by Bank transfer at the conclusion of the Insurance contract;

6.6.2. unless otherwise provided in the Insurance contract, the date of payment of the Insurance premium shall be the date of payment of the Insurance premium in cash to the Insurer / representative of the Insurer, or the day of transfer of the Insurance premium to the account of the Insurer / representative of the Insurer;

6.6.3. the obligation to pay the insurance premium (contribution) by the Policyholder – legal entity shall be deemed fulfilled from the date of receipt of funds to the Bank account of the Insurer / representative of the Insurer.

6.7. In case of insurance in foreign currency equivalent, the Insurance premium shall be paid in rubles at the exchange rate of the Central Bank of the Russian Federation established for the respective foreign currency on the date of payment of the Insurance premium in cash or on the date of transfer of the Insurance premium by Bank transfer.

7. CONCLUSION, VALIDITY PERIOD AND TERMINATION OF THE INSURANCE CONTRACT

7.1. The Insurance contract is concluded on the basis of a written or verbal application of the Policyholder.

The Insurance contract must be concluded in writing and meet the General conditions for the transaction validity provided for by the civil legislation of the Russian Federation.

7.2. Upon conclusion of the Insurance contract, an agreement on the following issues should be reached:

- on the Insured person;
- on the nature of the event, occurrence of which in the Insured person's life is covered by the insurance (the insured event);
- on the amount of the sum insured;
- on the validity period of the Insurance contract;
- on the train number, date and points of departure and destination.

7.3. Upon conclusion of the Insurance contract, the Policyholder (Insured person) shall be obliged to inform the Insurer of all circumstances known to him that are material for determining the degree of risk.

Under any conditions, the circumstances specified by the Insurer in the standard form of the Insurance contract (Insurance policy) shall be considered as material.

7.4. In order to determine the legal capability of the Policyholder and fulfillment of the requirements established by the current legislation of the Russian Federation at the stage of preparation for the conclusion of Insurance contracts, the Insurer has the right to request and check the following documents of the Policyholder:

7.4.1. for Policyholders - residents of the Russian Federation (legal entities / individual entrepreneurs):

- constituent documents (Charter, amendments to the Charter (if any));
- identity card (passport) (in case of conclusion of Insurance contracts with individual entrepreneurs);
- certificate of registration in the Unified State Register of Legal Entities (EGRUL), the Unified State Register of Individual Entrepreneurs (EGRIP);
- certificate of registration with the tax authority;
- extract from the EGRUL - for legal entities, extract from the EGRIP - for individual entrepreneurs (issued by the Inspectorate of the Federal Tax Service of the Russian Federation). The time period between the date of issue of an extract from the EGRUL (EGRIP) and the date of its submission to the Insurer shall not exceed 30 calendar days;
- information letter on registration in EGRPO (with statistics codes);
- documents confirming the powers of the person signing the Insurance contract on behalf of the Policyholder (decision of the authorized body of the Policyholder on election (appointment) of the sole Executive body (minutes of the General meeting of shareholders (participants, members, etc.), a copy of the passport), the Board of Directors (Supervisory Board), etc.), orders on appointment and dismissal of the previously acting head (if appointed), power of attorney to sign the Insurance contract with a specimen signature (in case of signing the Insurance

contract by a non-sole Executive body), if the power of attorney does not contain a specimen signature of the attorney, a notarized copy of the passport sheet of the attorney containing his full name and a sample of personal signature);

- decision of the authorized body of the Policyholder (General meeting of the shareholders (participants, members), the Board of Directors (Supervisory Board) to authorize (approve) the conclusion of the Insurance contract if the adoption of the relevant decision is required in accordance with the constituent documents of the Policyholder and/or the current legislation of the Russian Federation.

7.4.2. for Policyholders - residents of the Russian Federation (Individuals):

- identity card (passport);
- mandatory pension insurance certificate;
- certificate of registration with the tax authority;

7.4.3. for Individuals and individual entrepreneurs who are not citizens of the Russian Federation: additional documents confirming the right of a foreign citizen or a stateless person to stay (reside) in the Russian Federation;

7.4.4. for foreign counterparties (non-residents of the Russian Federation):

- documents confirming the legal capability of a foreign counterparty (registration of the foreign legal entity);
- provision on the branch, representative office, if the foreign counterparty acts through a branch or representative office established in the territory of the Russian Federation;
- documents confirming the registration (accreditation) of the foreign organization branch and its registration with the tax authorities;
- documents confirming the authority of the person signing the Insurance contract on behalf of a foreign counterparty.

Documents must be duly legalized.

Documents drawn up in a foreign language must be accompanied by a translation into Russian, with the fidelity certified by a notary.

7.4.5. The Insurer has the right to take additional measures to verify the reliability of the prospective partner (Policyholder) and additionally apply to the Policyholder for the following documents:

- certificate of existence of arrears or overpayments to the budget as of the date of the conclusion of the Insurance contract (signing of the additional agreement on the prolongation of the Insurance contract);
- copy of the VAT return for the last reporting period with the mark of the tax authority;
- copy of the Policyholder’s balance sheet for the last reporting period with the mark of the tax authority;
- copy of the insurance contract for the lease of the premises in which the Policyholder is registered;
- copy of the Bank card with the specimen signature and the seal.

The Insurer has the right to request document confirming the entitlement of the Policyholder for the STS, UTII, as well as a copy of the relevant tax Declaration submitted to the tax authority in connection with the application of STS, UTII by the Policyholder within the last tax period, or a document issued by the tax authorities confirming the application of STS, UTII by the Policyholder at the time of concluding the contract.

The documents mentioned above shall be provided in the form of originals for certification of the authenticity of the original copy by the Insurer's representative (in accordance with the powers vested in him to certify copies of documents) or in the form of copies certified in accordance with the procedure provided for by the current legislation.

7.5. The Insurance contract, unless otherwise provided herein, shall enter into force upon the payment of the Insurance premium.

The Insurance coverage under the Insurance contract shall be valid during the trip of the Insured person on the route specified in the travel document in the manner prescribed by clause 4.5. of the Rules.

7.6. For concluding group Insurance contract, the Policyholder shall provide the Insurer with a list of Insured Persons, which shall be an integral part thereof.

7.7. The Insurance contract can be concluded by drawing up one document – the contract, signed by the parties, or by delivering the Insurance policy, signed by the Insurer, to the Policyholder on the basis of his verbal or written application.

In case of loss of the insurance contract/policy during its validity period, the Insurer issues a duplicate of the Insurance contract/policy on the basis of Policyholder's written application, after which the lost contract shall be deemed cancelled.

7.8. The Insurance contract shall be terminated in the following cases:

7.8.1. expiration;

7.8.2. fulfillment by the Insurer of his obligations under the Insurance contract in full;

7.8.3. by agreement of the parties;

7.8.4. in other cases stipulated by legislative acts of the Russian Federation.

7.9. The Policyholder has the right to cancel the Insurance contract at any time before the departure of the vehicle.

If the Policyholder cancels the Insurance contract before the departure of the vehicle (the beginning of the insurance under the Insurance contract), the Insurance premium paid to the Insurer shall be returned to the Policyholder in full.

In case of refusal of the Policyholder – Individual from the insurance contract within 5 working days from the date of its conclusion in the absence of events having characteristics of Insured event, and before the end of the insurance, the paid Insurance premium shall be returned to the Policyholder within 10 working days:

- in full, if the cancellation of the contract took place before the date of commencement of the insurance;
- with the deduction by the Insurer of part of the Insurance premium in proportion to the term of the insurance, if the cancellation of the contract took place after the start of the insurance.

The Insurance contract shall expire at 11.59 pm on the date of receipt by the Insurer of the Policyholder's written application about its cancellation.

7.10. Unless otherwise explicitly provided for in the Insurance contract, the territory of insurance shall include all countries of the world, excluding civil unrest, declared state of emergency or conducted military operations areas, or their equivalents.

8. RIGHTS AND OBLIGATIONS OF THE PARTIES

8.1. *The Insurer shall be obliged to:*

8.1.1. issue the Insurance policy (policy) to the Policyholder with these Rules attached;

8.1.2. upon occurrence of an insured event, to pay the Insurance benefit within the period established by these Rules or the Insurance contract, or if there are no grounds for this, send a reasoned conclusion to the Beneficiary (Insured person) about the reject of the insurance claim;

8.1.3. maintain confidentiality in respect of the information about the Policyholder (Insured person), Beneficiary and their property and health status, unless this contradicts the legislation of the Russian Federation;

8.1.4. explain the provisions contained in these Rules and the Insurance contract upon request of the Policyholder (Insured person), the Beneficiary, or persons intending to conclude an Insurance contract.

8.2. The Insurer shall be entitled to:

8.2.1. conduct independent investigation of the circumstances of the event**.** If necessary, demand from the Policyholder (Insured person) materials of judicial or investigative bodies, documents issued by the carrier, certificates, invoices and other documents confirming the fact of the event, its details and consequences;

8.2.2 send the Insured person to undergo a survey in a medical facility (hereinafter - the medical facility) specified by the Insurer, in the scope set by the Insurer, in order decide if the event with characteristics of an Insured event should be recognized as insured event. Such surveys, depending on the circumstances of the event, might include: X-ray, EEG (electroencephalography), REG (rheoencephalography), echoencephalography, CT, MRI, other tests and methods. Medical examinations (tests) specified in this clause shall be carried out at the expense of the Insurer.

8.2.3. check the information provided by the Policyholder (Insured person), as well as the performance of the Policyholder's obligations;

8.2.4. advise the Policyholder on the prevention of Insured events;

8.2.5. reject payment of Insurance benefit, in the cases provided for by the insurance Rules and the current legislation of the Russian Federation;

8.2.6. demand fulfillment of other conditions stipulated by the legislation and the Insurance contract.

8.3. The Policyholder (Insured person) shall be obliged to:

8.3.1. pay the insurance premium before the start of the trip;

8.3.2. comply with personal safety measures, and with the rules established for passengers of railway transport during the validity of the Insurance contract;

8.3.3. inform the Insurer about the occurrence of the Insured event within the time period established by the Insurance contract and these Rules;

8.3.4. provide the safety of the Insurance contract and documents related to the Insured event;

8.3.5. provide availability of all possible documentary evidence of the Insured event occurrence, and submit them the Insurer;

8.3.6. inform Insured persons about their rights, obligations and the terms of insurance;

8.3.7. immediately contact the medical facility and strictly follow the recommendations of specialists of medical facilitys engaged in therapeutic and preventive measures in connection with the Insurance event;

8.3.8. comply with the terms of this Rules**.**

8.4. The Policyholder shall be entitled to:

8.4.1. receive these Rules from the Insurer;

8.4.2. receive information about the Insurer in accordance with the legislation of the Russian Federation;

8.4.3. prematurely terminate the Insurance contract in accordance with these Rules and the legislation of the Russian Federation;

8.4.4. require the Insurer to comply with other conditions stipulated in the Insurance contract and not contradicting to the legislation of the Russian Federation.

8.5. The Beneficiary shall be obliged to perform the obligations of the Policyholder, that were not executed by the latter upon submission of the insurance benefit payment request.

8.6. The Beneficiary shall be entitled to receive the insurance benefit in the manner and in the amount provided for by these Rules and the Insurance contract.

9. PROCESSING POLICYHOLDER'S AND OTHER PERSON'S PERSONAL DATA BY THE INSURER.

9.1. By entering into an Insurance contract on the basis of these Rules, the Policyholder confirms his consent to the fact that the Insurer or a third party authorized by him may in any legal way process the personal data of individuals specified therein in accordance with the Federal law dated July 27, 2006 No. 152-FZ "On personal data".

9.2. The processing of personal data in these Rules shall include: collection, systematization, accumulation, storage, clarification (update, change), use, depersonalization, blockage, destruction, as well as other procedures with personal data of individuals for statistical purposes and for the analysis of Insurance risks, or other purposes related to the execution of the Insurance contract.

9.3. The parties to the Insurance Contract entered into pursuant to these Rules shall consider confidential the information:

9.3.1. on personal data of the Policyholder (Insured person): surname, name, patronymic, year, month, date of birth, number of the main identity document, information about the date of its issue and the issuing authority, address, contact information;

9.3.2. on personal data of the Insured person of special category: data on the health status of the Insured person, diseases of the Insured person, as well as on cases of his request for medical care, if such information was available to and obtained by the Insurer.

9.4. The Policyholder undertakes to notify the Insured person / Beneficiary of the fact of transfer of his personal data for processing by the Insurer for the purpose of providing insurance services, as well as of the composition of the personal data transferred to the Insurer. The users of the transferred personal data shall be the employees of the Insurer and the third parties authorized by him.

The Policyholder undertakes to obtain the consent of Individuals specified in the Insurance contract to the processing of all categories of personal data (including special data, and the health data), and to the transfer of these personal data by the Insurer to third parties, including cross-border transfer, if necessary for the purpose of execution of the Insurance contract.

9.5. In order to execute the Insurance contract, the Insurer shall be entitled to transfer the personal data that became known to him in connection with the conclusion and execution of the Insurance contract to third parties with whom the Insurer has concluded appropriate agreements ensuring reliable storage and prevention of unlawful disclosure (confidentiality) of personal data.

The Insurer undertakes to ensure the safety and non-disclosure of personal data of the Policyholder and other Individuals specified in the contract, for purposes other than those provided for in this section of the Rules.

9.6. Consent to the processing of personal data shall be granted for the period necessary for the Insurer to execute the Insurance contract and conduct insurance business. Consent to the processing of personal data may be revoked by the owner of personal data in full by sending a written application to the Insurer in a manner that reliably defines the date of receipt of this application by the Insurer.

In case of full revocation by the owner of personal data of his consent to the processing of personal data, the Insurance contract shall be terminated in respect of thisperson; and in case of revocation of such consent by the owner of personal data - Policyholder, the Insurance contract shall be terminated completely. In this case, the Insurance contract shall be terminated prematurely from the date of receipt by the Insurer of the relevant application for revocation of consent to the processing of personal data.

9.7. After the termination of the Insurance contract (including its cancellation), as well as in case of revocation by the owner of personal data of his consent to the

processing of personal data, the Insurer undertakes to destroy such personal data within the period established by the current legislation of the Russian Federation.

9.8. The Insurer undertakes to comply with the principles and rules of personal data processing provided for by the Federal law dated July 27, 2006 No. 152-FZ "On personal data", to observe the confidentiality of personal data and to ensure the security of personal data processing, as well as to comply with the requirements for the protection of processed personal data established by article 19 of the Federal law dated July 27, 2006 No. 152-FZ "On personal data".

10. OBLIGATIONS OF THE POLICYHOLDER (THE INSURED PERSON) UPON THE OCCURRENCE OF THE EVENT HAVING CHARACTERISTICS OF INSURED EVENT

10.1. Upon the occurrence of an event having characteristics of an Insured event, the Policyholder (Insured person) shall be obliged to:

- apply to the master of the train (representative of the carrier) for the issue of a standard certificate (report) about the accident with the insured passenger during the railway trip;
- upon arrival at the destination point immediately, no later than 24 hours from the moment of arrival, contact the medical facility (its department) for medical assistance and for obtaining the necessary documents confirming his injury, its nature (diagnosis), the duration of continuous treatment and temporary disability, the conducted medical procedures and other information;
- within 60 days from the date of occurrence of the event having the characteristics of the Insured event, notify the Insurer or its representative in writing or by any fixed method of communication about the damage to health or death of the Insured person;
- submit to the Insurer the documents necessary for the recognition of the Insured event.

10.2. Depending on the nature and circumstances of the event having characteristics of the Insured event, in accordance with the specific Insured risk, the Insurer may request from the Policyholder (Beneficiary, Insured person, heirs) documents an exhaustive list of which is established in this Section of the insurance Rules.

The Insurer has the right to reduce the list of mandatory documents, if the circumstances of the Insured event or the amount of damage in accordance with the previously provided documents are known or obvious to him.

To resolve the issue of recognition/non-recognition of the claimed event as an Insured event, the following documents must be submitted to the Insurer by the Beneficiary (Insured person, heir, heirs):

- Insurance policy (if the Policyholder was a Individual);
- Insurance contract and list of Insured persons (if the Policyholder was a legal entity);
- written application of the Beneficiary in the form established by the Insurer for receiving the Insurance benefit with indication of the desired method of payment (bank transfer to the current account with indication of full bank details);
- identity document of the Insured person;
- document confirming the authority of the representative of the Insured person, the Beneficiary or the heir;
- travel document (ticket) confirming that the Insured person was a passenger and was traveling by rail along the route specified in the ticket at the time of the occurrence of the event having characteristics of Insured event;
- document about the accident and its circumstances, issued as prescribed by the rules for the transportation of passengers by rail:

• accident report issued by the carrier, if the accident occurred during the trip of the passenger train or at the time of boarding/disembarking of the passenger;

• accident report issued by the responsible employees of the railway station (station), if the accident occurred on the territory of the railway station, station;

• competent authorities' investigation documents about the fact of the reported event if such event is subject to investigation under the legislation of the Russian Federation;

• documents of law enforcement agencies about the circumstances of the event;

• results of chemical blood tests for alcohol, drugs, toxic substances upon admission to the hospital (if conducted);

• copy of the emergency call card (hereinafter - the EMS).

10.2.1. Additionally, the following documents must be provided to the Insurer in case of occurrence of the "Temporary loss of general working capability as a result of an accident" or the "Permanent loss of general working capability (disability) as a result of an accident" risks:

• for inpatient treatment - a check out summary from the inpatient's medical record (extract from the medical record) from the date of the initial appeal under the reported event (original or a duly certified copy);

• for outpatient treatment - a check out summary from the outpatient's medical record from the date of the initial application under the reported event (original or a duly certified copy); The document must contain a stamp and seal of the medical facility;

• copies of disability certificates issued for payment and verified by the HR department officer and bearing the seal of HR department of the organization in which the Insured person works, or duly verified copies of student's temporary disability certificate;

• medical documents indicating the full clinical diagnosis, terms of treatment, therapeutic and diagnostic measures for the entire period of treatment; from all medical facilitys in which the Insured person received medical assistance in connection with the reported event;

• Medical and Social expertise service Bureau certificate on assignment of the disability group or category "disabled child" (original or a notarized copy);

• referral for medical and social expertise, return slip of the Medical and Social expertise service Bureau (duly certified copies).

10.2.2. Additionally, the following documents must be provided to the Insurer in case of occurrence of the "Death as a result of an accident» Insured risks:

• death certificate of the Insured person (original or a notarized copy);

• duly certified of copy of the medical death certificate or copy of the forensic medical examination report with the results of forensic chemical and forensic biological researches;

• copy of the relatives' application for waiver of the autopsy and copy of department of morbid anatomy certificate, on the basis of which the death certificate was issued (if no autopsy was performed);

• original order of the Insured person stating who was designated as the recipient of the Insurance benefit in the event of his death or the original certificate of inheritance;

• copy of a document (passport or document replacing it) verifying the identity of recipient of the Insurance benefit under the Insurance contract, with indication of the registration at the place of residence;

• documents confirming entry into inheritance rights (certificate of inheritance or other documents confirming entry into inheritance rights under the Insurance contract).

10.3. If the event, having characteristics of Insured event, occurred with the Insured person outside the Russian Federation, along the route of the international passenger train, and if the medical care was provided in the territory of another state, the Insurer must be provided with medical and other documents, allowing to confirm the occurrence of the Insured event with the Insured person and the nature of his damages, with an apostille affixed (at the request of the Insurer). Documents in a foreign language shall be provided along with their notarized translations. The cost of collecting these documents and their translation shall be paid by the recipient of the insurance benefit.

10.4. The Insurer shall be submitted documents issued and executed by the medical organization in accordance with the procedure established by the legislation of the Russian Federation (with indication of the surname, name and patronymic of the Insured person, date of birth / age, main clinical diagnosis, etc.), certified by the seal of the medical facility.

If the Beneficiary is under 14 y., and his parent, adopter or guardian is entitled to receive the insurance benefit, then the documents confirming the right to receive the insurance benefit by the applicant (copy of the birth certificate of the minor recipient of the payment, notarized copies of the guardianship/adoption documents) should be submitted.

If the Beneficiary is under 14 y.o., the insurance benefit shall be paid to the settlement account opened in his name or to the settlement account of the legal representative of the minor (father, mother).

If guardianship/trusteeship of the minor Beneficiary was issued and the guardian/trustee is entitled to receive the Insurance benefit according to article 37 of the Civil Code of the Russian Federation, the Insurer must also be presented the documents confirming the right to receive the Insurance benefit by the applicant (notarized copies of documents on guardianship/adoption, permission of the Trusteeship and Guardianship authority).

If the Beneficiary is legally incapable and his guardian is entitled to receive the Insurance benefit, the documents confirming the right to receive the insurance benefit by the applicant (notarized copies of the guardianship documents, permission of the Trusteeship and Guardianship authority) must be submitted as well.

If the Insured person / Beneficiary entrusts the receipt of the insurance benefit to a third party, a notarized power of attorney for the right to receive the insurance benefit must also be submitted.

All documents stipulated by this Section and provided to the Insurer in connection with insurance benefits shall be issued in Russian. If the documents provided to the Insurer are issued on the territory of a foreign state, then they must be properly legalized, have an apostille (if applicable) and/or a notarized translation. In case of submission of documents that can not be read due to the peculiarities of the handwriting of a doctor or an employee of the competent authority, as well as due to violation of the integrity of the document, the Insurer shall be entitled to postpone the decision on the reported event until the provision of documents of proper quality.

10.5. If the submitted documents do not contain information necessary for making a decision on the insurance benefit payment (or determining its amount), or contain contradicting information, the Insurer shall have the right to request additional documents necessary for making a final informed decision, and also to carry out an examination of the submitted documents, independently clarify the causes and circumstances of the Insured event.

The insurer shall have the right to extend the period for making a decision on qualification of the event until the Insured person (Beneficiary) submits the documents specified in Chapter 10 and required for the assessment of its circumstances.

In case of doubts about the authenticity and/or reliability and sufficiency of the documents submitted by the Insured person (Beneficiary) in connection with the

occurrence of an event having characteristics of Insured event, or to confirm the state of disability, including the assignment of a disability group, the Insurer shall be entitled to send the Insured person for repeated laboratory and instrumental examinations (including ultrasound, x-ray and other methods of radiation diagnosis) or repeated medical examinations carried out by doctors of various specialties. These studies and medical examinations shall be carried out by doctors designated by the Insurer at the places designated by the Insurer and at his expense.

The Insured person and Beneficiaries shall be obliged to provide the Insurer or his representative with free access to information related to the insured event.

11. THE AMOUNT AND PROCEDURE OF PAYMENT OF THE INSURANCE BENEFIT

11.1. Insurance benefit – a sum of money established by the Insurance contract and paid by the Insurer to the Policyholder (Insured person, Beneficiary) upon the occurrence of an Insured event.

11.2. The Insurance benefit shall be paid by the Insurer to the Insured person (Beneficiary) or heirs within the limits of the individual sum insured specified in the Insurance contract.

11.3. Upon the occurrence of the Insured event, the amount of the Insurance benefit shall be determined in accordance with the terms of the Insurance contract:

11.3.1 Upon the occurrence of the “Temporary loss of general working capability as a result of an accident” Insured event, the Insurance benefit shall be paid to the Insured person “according to the number of days of temporary disability” (continuous treatment); the Insurance benefit amount shall be 0.3% of the sum insured for each day of temporary disability (continuous treatment), starting from the first day, but not more than 100 (one hundred) days of continuous treatment and not more than the sum insured established to the Insured person.

11.3.1.1 The Insurance contract may provide for a different amount of payments for a day of temporary loss of general working capability; in this case:

- the insurance rate shall change proportionally to the ratio of the percentage of payments established in clause 11.3.1. of these Rules and the percentage of payments established under the Insurance contract;

- the percentage of payments for each day of temporary loss of general working capability may not be less than 0.01% and more than 3.00% of the sum insured.

The number of days of loss of general working capability or temporary health disorder shall be calculated from the date of application for medical care to the medical facility on the basis of medical documents issued by the medical facility (certificates, statements, medical record summaries, outpatient cards), as well as taking into account documents confirming temporary disability, temporary health disorder (disability certificates, conclusion of a medical commission, exemption certificate from official duties due to temporary disability).

11.3.1.2 The Insurance contract may establish a different maximum period of continuous treatment, which shall be paid in connection with occurrence of one Insured event.

11.3.1.3 The Insurance contract may set the maximum Insurance benefit for one Insured event.

11.3.2 Upon occurrence of the “Permanent loss of general working capability (disability) as a result of an accident” Insured event for persons who were not disabled before entering into the Insurance contract, the Insurance benefit shall be paid to the Insured person in the following portions of the sum insured (unless otherwise provided

by the Insurance contract), depending on the assigned disability group (Annex 1 to these Rules):

for the 1st disability group – 100% of the sum insured;

for the 2nd disability group – 70% of the sum insured;

for the 3rd disability group – 40% of the sum insured.

For persons who belonged to the 3rd disability group before entering into the Insurance contract, the Insurance benefit shall be paid to the Insured person in the following portions of the sum insured (unless otherwise provided by the Insurance contract), depending on the assigned disability group:

for the 1st disability group – 100% of the sum insured;

for the 2nd disability group – 70% of the sum insured;

For persons who belonged to the 2nd disability group before entering into the Insurance contract, the Insurance benefit shall be paid to the Insured person in the following portions of the sum insured (unless otherwise provided by the Insurance contract), depending on the assigned disability group:

for the 1st disability group – 100% of the sum insured;

If the "disabled child" category is assigned to a child under 18, the amount of the Insurance benefit shall be 100% of the sum insured**.**

If the "disabled child" category has already been assigned to the Insured person before the conclusion of the Insurance contract, the Insurance benefit for such a risk shall not be paid.

11.3.2.1 If the Insured person was assigned the 3rd group of disability and received the lump sum insurance benefit, the assignment of the 2rd group of disability to the Insured person under the same accident, shall lead to payment of the insurance benefit in the amount of the difference the payment made for the 3rd group of disability and the payment due for the 2nd group of disability.

If the Insured person was assigned the 2nd group of disability and received the lump sum insurance benefit, the assignment of the 1st group of disability to the Insured person under the same accident, shall lead to payment of the insurance benefit in the amount of the difference the payment made for the 2nd group of disability and the payment due for the 1st group of disability.

The Insurance benefit in the amount of the arising difference shall be paid if the Insurer was notified of the change in the disability group within one year after the occurrence of the Insured event and the relevant documents were provided.

11.3.3 Upon occurrence of the "Death as a result of an accident" Insured event, the Insurance benefit shall be paid to the Beneficiary or heir(s) in the amount of 100% of the sum insured;

11.3.4 If after the insurance benefit payment for temporary loss of general working capability or temporary disruption of health, the Insured person became disabled or died due to the same accident, the amount of previously paid Insurance benefit shall be deducted from the sum insured payable.

11.4. If the Insured person is under 14 y.o., the insurance benefit due to him shall be paid to the legal representatives of the child (one of the parents living with the child or the guardian) or shall be transferred to a bank account specified in the Insurance benefit application in the name of the Insured person.

If the Beneficiary or heir (s) is under 14 y.o., the amount due to him shall be transferred to a bank account in his name, with the notification of the guardianship or trusteeship authorities, if necessary.

11.5. The insurance benefit shall be paid by the Insurer in accordance with the Insurance contract on the basis of the application of the Insured person, Beneficiary or heirs of the Insured person and the insurance act issued by the Insurer.

11.6. In case of recognition of the reported event as an Insured event, the Insurance benefit shall be paid to the Insured person (Beneficiary) or the heir (s) of the

Insured person within 10 (ten) working days from the date of receipt of all necessary documents, specified in clause 10.2. these Rules.

11.7. If the death of the Policyholder (Insured person) occurred as a result of intentional actions of the Beneficiary, which caused the occurrence of the Insured event, the Insurance benefit shall be paid to another Beneficiary (Beneficiaries). If only one Beneficiary has been appointed under the Insurance contract, the Insurance benefit shall be paid to the heirs of the Insured person in the manner prescribed by law.

11.8. If the Beneficiary applied to the Insurer for the Insurance benefit and died before receiving the amount of the Insurance benefit due, the payment shall be made to his heirs on the basis of the certificate of inheritance.

11.9. If the reported event is not recognized as an Insured event, the Insurer shall be obliged to notify the Policyholder about it in writing, stating the reasons for the refusal within 10 (ten) working days from the date of submission of all necessary documents by the Policyholder, the Insured person or the Beneficiary.

11.10. At the request of the Insured person, the Beneficiary or the heir, the Insurance benefit shall be paid by transfer of funds to the settlement account. The owner of the account bears all the expenses for banking services related to the transaction of the Insurance benefit.

11.11. The insurer shall be entitled to extend the time of making a decision on insurance benefit payment:

- if the Insurer has requested from the Insured person, Beneficiary, Policyholder or competent authorities additional documents necessary to confirm the fact of occurrence of the Insured event, the deadline for making a decision on the reported event specified in clause 11.6. of these Rules shall be extended until the date of receipt by the Insurer of additional documents and/or until the date of completion of the verification of the circumstances specified in paragraph 3 of clause 10.5 of these Rules.

- if the relevant competent authorities have initiated a criminal case related to the Insured event, or the circumstances leading to the occurrence of the Insured event are being investigated, and if such activities might affect the results of the decision on qualification of the insured event, then the decision shall be postponed until the end or suspension of the criminal proceedings (whichever occurs earlier).

11.12. In case of request of additional documents, as well as in case of initiation of a criminal case or investigation of the circumstances that led to the occurrence of the Insured event, the Insurer shall inform the person applying for the Insurance benefit of an extention in the processing time within 5 working days.

12. DISPUTE SETTLEMENT PROCEDURE

All disputes under the Insurance contract between the Insurer and the Policyholder shall be settled through negotiations, and in case of failure to reach agreement, in a court of law.