JOINT STOCK COMPANY
INSURANCE COMPANY OF GAS INDUSTRY

A P P R O V E D

by Order of SOGAZ JSC
dated December 27, 2017 No. 716

RULES FOR VOLUNTARY INSURANCE OF PASSENGERS

1. GENERAL PROVISIONS

1.1. In accordance with the legislation of the Russian Federation and on the basis of these Rules, SOGAZ JSC (hereinafter referred to as the Insurer) concludes voluntary accident insurance contracts for passengers with viable individuals, legal entities and individual entrepreneurs (hereinafter referred to as the Insured). Under these Rules and in accordance with the conditions set forth in the Rules and the insurance contract, individuals may be insured against accidents during their trip as passengers by rail, air, water, motor transport.

1.2. When concluding an insurance contract under the terms of this Regulation, the insurance contract must explicitly state the application of the Rules.

When concluding an insurance contract, the parties may agree to amend or exclude certain provisions of these Rules from the terms of the insurance contract, provided that such changes or exceptions do not contradict the legislation of the Russian Federation and these Rules.

1.3. The insurer is entitled, on the basis of these Rules, to develop various insurance programs for a separate insurance contract or for individual 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 be entitled to disclose information received by them as a result of their professional activity about the Policyholder, the Insured Person, the Beneficiary, their health status and property status, unless otherwise provided by the legislation of the Russian Federation.

1.5. In accordance with the legislation of the Russian Federation, the insurance payment is made to the Beneficiary or another person entitled to receive insurance payment, regardless of the amounts due to them under other insurance contracts, as well as compulsory social insurance, social security and compensation for harm.

1.6. The main terms used in these Rules and the insurance contract:

1.6.1. *Accident* – a sudden, transient, unforeseen event actually occurred within the term of the insurance contract and during the trip (hereinafter defined according to cl. 4.5. hereof), regardless of the will of the Insured and/or the Policyholder and/or the Beneficiary, resulting in a traumatic injury, acute poisoning (other than food toxic infection, poisoning by alcohol, narcotic, psychotropic substances), which is not a consequence of a disease, that occurred to the Insured in a vehicle or on a territory of a station, roadside station, passenger platform, airport and the like facilities designed to serve passengers, as a result of which there was a temporary or permanent loss of the general working capacity by the Insured or his/her death.

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

1.6.2. *Temporary loss of general working capacity* – disability caused by an accident that occurred within the term of the insurance contract during the trip of the Insured as a passenger, accompanied by the inability to perform his/her work duties for the period necessary for the continuous treatment of the consequences of the accident.

For non-working Insured Persons, including children under the age of 18 years and retirees, temporary loss of total work capacity is understood to be a temporary acute health disorder as a result of an accident, that occurred during the term of the insurance contract during the Insured's trip as a passenger, which required treatment for a certain limited continuous period of time.

Continuous treatment is understood only as treatment prescribed by a medical worker, who has the right, according to medical science, the nature of the damage received by the Insured, with periodic (at least once every 10 days) control of its effectiveness (directly at a medical organization or at home, when a medical worker visits the Insured).

The period of continuous treatment does not include the time, during which periodic preventive measures are taken for the Insured Person (for example, vaccination against tetanus, rabies, etc.) resulting from an accident and injuries carried out beyond the period of treatment. The specified time is not taken into account, when calculating the insurance payment for the risk of temporary loss of general working capacity.

1.6.3. *Persistent loss of general working capacity (disability)* of the Insured – social insufficiency of the Insured due to impairment of health with persistent disorder of body functions due to an accident that occurred within the period of validity of the insurance contract during the trip of the Insured as a passenger and that resulted in disability and the need for social protection.

Disability groups correspond to the groups established by the Bureau of Medical and Social Assessment (hereinafter - the MSA Bureau) to characterize the degree of disability and the requirements of care, indications and contraindications of a medical nature.

1.6.4. *Passenger* – an individual, in respect of whom a contract for the carriage of a passenger has been concluded and who is traveling on board transport under a valid travel document (a ticket).

A trip by transport also includes the carriage of a passenger in a certain part of the route by another type of transport, if such carriage is carried out for the purpose of fulfilling by the carrier of its obligation to transport the passenger to the destination in accordance with the transportation agreement (travel document) concluded with this passenger. An insurance contract may provide for insurance of a passenger when he/she is transported to his/her destination on several types of transport (hereinafter referred to as the multimodal transportation).

1.6.5. *Transit passenger on air transport* – a person who, in accordance with the air carriage contract, arrives at the intermediate airport and is transported further by the same flight to the airport at the destination.

1.6.6. *Transfer passenger on air transport* – a person who, in accordance with the air carriage contract, is delivered to the point of transfer by one flight, and then is transported by another flight of the same or another carrier.

2. SUBJECTS OF INSURANCE

2.1. The subjects of insurance are the Insurer, the Insured, the Insured and the Beneficiary.

2.2. **Insurer** – Joint Stock Company Insurance Company of the Gas Industry (SOGAZ JSC), 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. **Insured** – a capable individual, legal entity or individual entrepreneur, who has entered into an insurance contract with the Insurer with respect to the life and health of the Insured Persons.

2.4. **Insured person** – an individual in respect of whose life and health an insurance contract has been concluded and who is travelling on transport as a passenger on the route (journey) specified in the insurance contract.

The insured person named in the insurance contract may be replaced by the insured by another person only with the consent of the insured person and the insurer.

2.5. **Beneficiary** – is an individual, in whose favour an insurance contract has been concluded and who is entitled to an insurance payment.

The Policyholder, with the written consent of the Insured Person, has the right to designate any person as a beneficiary of the insurance payment (hereinafter referred to as the Beneficiary).

If the Beneficiary is not appointed, then the Insured person is recognized as the Beneficiary, and in case of an event provided for by cl. 4.2.3. hereof, - their heir (heirs).

2.6. During the validity period of the insurance contract, with the written consent of the Insured (his/her legal representative), the Policyholder may replace the Beneficiary specified in the

insurance contract with another person, by 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 made a claim to the Insurer for insurance payment.

3. INSURANCE OBJECT

3.1. The object of insurance are the property interests associated with causing harm to the health of the Insured person, as well as their death in an accident that occurred during the travel.

4. INSURANCE RISKS. INSURED EVENTS

4.1. Insurance risk shall be deemed to be an anticipated event that bears signs of probability and contingency of its occurrence, against the possibility of which the insurance is carried out. An insured event is the event, described as an insured risk.

Insured event is an occurred event provided for in the insurance contract, which occurrence gives rise to the Insurer obligation to pay an insurance benefit to the Insured or Beneficiary.

4.2. The following events are recognized as insured events under these Rules, with the exception of the events specified in clause 4.6 of these Rules, which occur with the occurrence of the Insurer's obligation to make an insurance payment to the Insured (Beneficiary):

4.2.1. *"Temporary loss of general working capacity as a result of an accident"* – temporary loss by the Insured of a general working capacity or temporary acute impairment of health as a result of an accident, that occurred during the validity of the insurance contract during the trip of the Insured as a passenger on board the railway transport, if there is a causal link between the accident and temporary loss of the general working capacity or temporary acute health disorder of the Insured.

4.2.2. *"The persistent loss of general working capacity (disability) as a result of an accident"* – the confirmation of disability of I, II, III group for the Insured, category "disabled child" - within 12 months (unless otherwise provided by the insurance contract) from the date of the accident, that occurred during the validity of the insurance contract during the Insured's trip as a passenger, if there is a causal link between the accident and the confirmation of disability of the Insured;

4.2.3. *"Death as a result of an accident"* – the death of the Insured person, which occurred within 12 months (unless otherwise provided by the insurance contract) from the date of the accident, that occurred during the validity of the insurance contract during the Insured's trip as a passenger, if there is a causal link between the accident and the death of the Insured.

4.3. Under these Rules, insured events, with the exception of the events specified in clause 4.6. hereof, are the events provided for in clause 4.2. hereof, resulting from an accident (cl. 1.6.1 hereof) that occurred to the Insured within the validity period of the insurance contract during the trip (cl. 4.5 hereof), and confirmed by the documents of relevant authorities drawn up in accordance with the law and these Rules.

4.4. Under these Rules, an insurance contract is concluded for a period of one or more trips by an Insured person on transport (the term of the insurance contract).

During the term of the insurance contract, insurance is valid only for accidents that occurred to the Insured during his/her travels as a passenger on a route (flight) specified in the insurance contract. The period of the trip is determined in accordance with cl. 4.5 hereof;

Consequences of accidents that occurred to the Insured Person outside of the travel periods determined in accordance with Cl. hereof are not insured and insurance payments for them are not made.

4.5. Unless otherwise expressly provided for in the insurance contract, the period of the Insured person's trip is determined as follows depending on the type of transport:

4.5.1. when using railway transport - it starts from the moment the Insured person arrives at the roadside station/station at the point of departure indicated in the ticket (travel document), but

not earlier than the announcement of boarding the vehicle, and not earlier than 30 minutes before the departure of the train, the number and date and time of departure of which are specified in the insurance contract (at the intermediate station during the course of the vehicle, not earlier than the moment the vehicle arrives at the roadside station/station) and ends, when the Insured person leaves the destination (roadside station/station), provided that there is an hour span from the time the vehicle arrives until the Insured Person leaves the destination (roadside station/station);

4.5.2. when using air transport - it starts from the moment the Insured person arrives at the airport building at the point of departure for the flight, the number, date and time of departure of which are specified in the insurance contract, but not earlier than 6 hours before the flight departure time specified in the ticket specified in the insurance contract, and ends when the insured person leaves the airport building at the destination.

At the same time, from the beginning of the trip until the insured person passes the pre-flight inspection at the airport of departure, the insurance is valid only when the insured person is in the territory (room) of the airport, except for territories (rooms) not intended for passengers.

In relation to the insured transit or transfer passenger on air transport (cl. 1.6.5, 1.6.6 of these Rules) insurance is valid when it is located on the territory (room) of the intermediate airport, except for the areas (premises) not intended for finding passengers during the entire period of waiting for them to board the aircraft on the flight specified in the insurance contract for the continuation of the flight. Insurance in respect of the insured transit (transfer) passenger is not valid during the period when it is located outside the territory (premises) of the intermediate airport or when it is located on the territory (room) not intended for the location of passengers;

4.5.3. when a passenger is transported by boat, the period of travel includes the period during which the Insured is on board, the periods of embarkation and disembarkation of the Insured, as well as the period during which the Insured is delivered by ship from shore to ship or vice versa, if the cost is such carriage is included in the ticket price or the vessel used for such auxiliary carriage is provided by the carrier to the Insured;

4.5.4. when a passenger is transported by road (long-distance or international bus) - it starts from the moment the Insured person gets into the vehicle at the point of departure and ends at the moment of departure from the vehicle at the destination, including staying at all stops along the way. The insurance is not valid when the Insured person is outside the vehicle and outside stopping points along the line.

4.6. Under the insurance contract in accordance with these Rules, events occurred to the Insured during the trip as a result of:

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

4.6.3. commission of an intentional crime by the Insured;

4.6.4. deliberate failure of the Insured to comply with the requirements of the train commander, aircraft commander, captain of a watercraft, station commander, airport, carrier representatives or other authorized officials;

4.6.5. intentional violation of transport regulations by the Insured person or any other event not directly related to the trip or passenger services;

4.6.6. diseases (acute, subacute, chronic (including mental), infectious, including those accompanied by intoxication) and post-traumatic conditions after the event (including post-traumatic arthritis/arthrosis, post-traumatic contracture, habitual dislocation, pathological fracture, damage to the capsular-ligamentous apparatus, post-traumatic encephalopathy, post-traumatic

stress disorder);

4.6.7. deliberate infliction and/or attempts to injure themselves (self-harm) by the Insured person, regardless of their mental health condition, or intentional infliction of injuries to the Insured person by any person with his consent, regardless of the mental state of the Insured person.

4.7. The insurer shall be exempt from the insurance payment, when the insured event occurred due to the intent of the Insured, the Insured Person, the Beneficiary.

4.8. Unless otherwise provided by the insurance contract, the Insurer shall be exempt from the insurance benefit, 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 actions;

4.8.3. civil war, public unrest of any kind or strikes;

4.9. The Insurer shall be entitled to refuse the insurance benefit, if the Insured (the Insured Person or his/her legal representative, Beneficiary) failed to notify the Insurer (or his/her representative) about the occurrence of the insured event (cl. 9.1 hereof), should it not be proved, that the Insurer had timely learned about the occurrence of an insurance event, or that the absence of information with the Insurer about it could not have affected the obligation thereof to make an insurance payment.

The failure of the Insurer to make an insurance payment may be appealed by the Insured (the Insured or his legal representative, the Beneficiary) in the manner prescribed by the legislation of the Russian Federation and the insurance contract.

5. INSURED AMOUNT

5.1. *Insured amount* – the sum of money determined by the insurance contract upon its conclusion, on the basis of which the amount of the insurance premium and the amount of the insurance payment are determined upon the occurrence of the insured event.

5.2. The insurance sum is determined by an agreement of the parties and is specified in the insurance contract.

The insurance sum is set to be uniform for all insurance risks stipulated by the insurance contract.

5.3. The insurance sum is set for each insured person (individual insurance sum).

The total amount of insurance payments for all insured events occurred to the Insured during the term of the insurance contract cannot exceed the amount of the individual insurance sum established for the Insured in the insurance contract, regardless of the number of his/her travels specified in the insurance contract..

5.4. The insurance amount is set in Russian roubles.

6. INSURANCE PREMIUM

6.1. *Insurance premium* – payment for insurance, which the Insured is obliged to pay to the Insurer in the manner and within the terms established by the insurance contract.

6.2. *Insurance tariff* – insurance premium rate per unit of insurance sum, taking into account the object of insurance and the nature of the insured risk, as well as other insurance conditions.

6.3. The amount of the insurance premium is set by the Insurer based on the insurance sum and the insurance tariff.

6.4. In determining the amount of insurance premium, the insurer is entitled to establish either increasing or decreasing coefficients (correction factors) to the basic insurance tariffs depending on the factors of insured risk and insurance conditions.

6.5. The insurance premium under the insurance contract is paid by the Insured one-time prior to the start of the trip (the first trip, if the insurance contract provides for several trips).

6.6. Insurance premium payment procedure (insurance contribution):

6.6.1. If a different period and payment procedure are not set by the parties in the insurance contract, the insurance premium under the insurance contract is paid by the Insured to the Insurer in cash or by bank transfer in a lump sum, when concluding an insurance contract;

6.6.2. The date of payment of the insurance premium (contribution) by the Insured - an individual is the following:

- when paying in cash - the date of cash crediting to the Insurer (the Insurer's representative) or paying agent (subagent), which is engaged in the activity of receiving payments from individuals;
- when paying by transferring cash without opening a bank account - the date of cash crediting to the credit institution or bank paying agent (subagent) operating in accordance with the legislation of the Russian Federation on the national payment system;
- when paid by transferring money within the framework of applied forms of cashless payments - the date of confirmation of its execution by a credit institution serving the Insured.

The date of payment of the insurance premium (contribution) by the Insured - a legal entity or an individual entrepreneur is considered to be:

- when paid in cash - the date indicated in the document confirming receipt by the Insurer (representative of the Insurer) of the insurance premium (installment);
- when paying by cashless settlement - the date of receipt of the insurance premium (contribution) to the current account of the Insurer or his representative.

6.6.3. Payment of insurance premium (contributions) to Insurer means its payment directly to Insurer or Insurer's representative. In the latter case, payment of insurance premium to Insurer's representative is equivalent to the same payment to Insurer.

7. CONCLUSION, TERM AND TERMINATION OF THE INSURANCE CONTRACT

7.1. The insurance contract is an agreement between Insurer and Insurant, by virtue of which Insurer undertakes to make insurance payment to the Insured (Beneficiary) for the contribution (insurance premium) specified in the contract upon occurrence of the events (insured events) stipulated in the contract in the manner and on the terms and conditions provided by the Regulations and the insurance contract.

Insurance contract shall be made on the basis of the Insured's oral request.

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

7.2. When concluding an insurance contract, an agreement shall be reached on the following conditions:

- the Insured;
- the nature of the event, on the occurrence of which the Insured (the insured event) is insured;
- the insurance sum;
- the term of the insurance contract;
- the number, date and time of departure of the vehicle by which the Insured person's trip is transported, on the trip route.

7.3. When concluding an insurance contract, the Policyholder (the Insured) is obliged to inform the Insurer of all known circumstances, that are essential for determining the degree of risk.

In any case, essential are the circumstances specified by the Insurer in the standard form of the insurance policy or written request.

7.4. When concluding an insurance contract, the Policyholder provides the documents and information required in accordance with the requirements of the current legislation of the Russian Federation for the identification of persons specified in the insurance policy.

The insurer is entitled to request from the Insured consent to the processing of personal data, as well as special category data (including medical confidentiality) - in cases where,

according to the legislation of the Russian Federation, the Insurer is not entitled to process personal data without such a consent.

In order to determine the legal capacity of the Insured and compliance with the requirements established by the current legislation of the Russian Federation, the Insurer has the right to request and verify the following documents with the Insured during preparation for concluding insurance contracts:

7.4.1. form the Insurers, who are residents of the Russian Federation (legal entities/individual entrepreneurs):

- constituent documents (Charter, changes to the Charter (if any));
- identity card (passport) (when entering into insurance contracts with individual entrepreneurs);
- certificate of registration in the Unified State Register of Legal Entities (UGRLE), the Unified State Register of Private Entrepreneurs (USRPE);
- certificate on registration in a taxation authority;
- extract from the UGRLE - for legal entities, extract from the USRPE - for individual entrepreneurs (issued by the Inspectorate of the Federal Tax Service of the Russian Federation). The time period between the issue date of an extract from the UGRLE (USRPE) and its submission date to the Insurer shall not exceed 30 calendar days;
- an information letter about registration with the USREO (with statistics codes);
- documents confirming the authority of the person signing the insurance contract on behalf of the Insured (the decision of the Insured's authorized body to elect (appoint) the sole executive body (minutes of the general meeting of shareholders (participants, members, etc.), copy of the passport), the board of directors (supervisory board) etc.), orders for the appointment and removal of the former head (if appointed), a power of attorney to sign an insurance contract with a sample of the signature (in case of signing the contract not by the sole executive body), if the power of attorney does not contain a sample of the signature of the attorney, a notarized copy of the sheet of the attorney's passport containing the full name and sample of their personal signature);
- Insured authorized body resolution (general meeting of shareholders (participants, members), the board of directors (supervisory board) on the permission (approval) to enter into an insurance contract, if the relevant decision is required in accordance with the constituent documents of the Insured and/or current legislation of the Russian Federation.

7.4.2. from the Insurers - residents of the Russian Federation (individuals):

- Identification document;
- insurance certificate of compulsory pension insurance;
- certificate on registration in a taxation authority;

7.4.3. from individuals and individual entrepreneurs, who are not citizens of the Russian Federation, additional documents may be requested confirming the right of a foreign citizen or stateless person to stay (reside) in the Russian Federation;

7.4.4. from foreign contractors (non-residents of the Russian Federation):

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

The said documents shall be properly legalized.

The insurer is entitled to demand the documents drawn up in a foreign language to be accompanied by a translation into Russian, the correctness of which is certified by a notary, the

Insured is obliged to provide a translation upon the Insurer's request.

7.4.5. The insurer is entitled to take additional measures to verify the reliability of the prospective partner (the Insured) and additionally contact the Insured for the submission of the following documents:

- a certificate of arrears or overpayment to the budget on the date of the conclusion of the insurance contract (signing of an additional agreement on the prolongation of the insurance contract);
- copy of the VAT tax return for the last reporting period marked by a tax authority;
- copy of the balance sheet of the Insured for the last reporting period marked by a tax authority;
- copy of the insurance lease contract for the premises, for which the Insured is registered;
- copy of the bank card with signature specimen and seal imprint.

From the Insurers applying the simplified taxation system, UTII, the Insurer is entitled to request a document confirming, that the insurer can use the simplified tax system, UTII, as well as a copy of the relevant tax declaration submitted to the tax authority in connection with the use of the simplified taxation system, UTII by the Insurer for the last tax period, or a document issued by the tax authorities confirming the use of the simplified tax system, UTII by the Insured at the time of the conclusion.

The above mentioned documents are provided in the form of originals for testimony by the representative of the Insurer (in accordance with the authority to certify copies of documents) of the correctness of a copy of the original or in the form of copies certified in accordance with the procedure established by law.

7.5. If it does not stipulate otherwise, the insurance contract shall enter into force on the date of payment of the insurance premium. The date of payment of the insurance premium is determined in the order specified in Cl. 6.6.2 hereof.

At the same time, the insurance under the insurance contract is valid during the period, when the Insured person travels along the route specified in the travel document in the manner prescribed in clause 4.5 of the Rules.

7.6. The Insured shall provide the Insurer with a list of Insured Persons for the conclusion of an insurance contract in respect of several Insured Persons.

7.7. The insurance contract is concluded by handing of an insurance policy signed by the Insurer by the Insurer to the Insured on the basis of his oral statement.

In case of loss of the insurance policy during the period of its validity, the Policyholder shall be provided with a duplicate of the insurance policy on the basis of his/her written application, after which the lost document is considered to be cancelled, and no payments thereunder shall be made.

7.8. The insurance contract is terminated in the following cases:

7.8.1. expiration;

7.8.2. complete fulfilment by the Insurer of its obligations under the insurance contract;

7.8.3. as agreed by the Parties;

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

7.9. Insurant has the right to refuse from the insurance contract at any time, unless by the time of the refusal the possibility of occurrence of the insured event has ceased to exist due to circumstances other than insured event.

7.9.1. The insurance premium paid to the Insurer shall be refunded to the Insured in full:

- if the Policyholder refuses the insurance contract until the start of the trip (the first trip, if the insurance contract provides for several trips), determined in accordance with cl. 4.5 hereof;
- if the Policyholder refuses the insurance contract at any time, if the passenger has not completed the trip (all trips, if the insurance contract provides for several trips), provided for by the insurance policy and the travel document (the insurance premium is refunded, if the Insured

confirms that the trip or all trips were not carried out).

7.10. If the Insured refuses an insurance contract within fourteen (14) calendar days from the date of its conclusion (unless otherwise specified by Bank of Russia Order No. 3854-У, dated 20.11.2015, “On Minimum (Standard) Requirements to the Conditions and the Procedure for Implementing Certain Types of Voluntary insurance "(hereinafter referred to as the “Order”) in the wording valid on the date of conclusion of the insurance contract), but after the start of the trip (first trip if the insurance contract provides for several trips), provided by the insurance policy and the travel document (subject to its implementation and in the absence of events having signs of an insured event), the insurer has the right to withhold the insurance premium in proportion to the insurance contract validity term from the date of commencement of insurance to the date of termination of the insurance contract.

7.10.1. In the case specified in cl. 7.10 hereof, the date of cancellation of the insurance contract shall be the date of submission to the Insurer by the Insured or his authorized representative of a written statement of withdrawal from the insurance contract.

If the specified application is sent by mail, the date of cancellation of the insurance contract shall be considered the date indicated on the postmark of the postal organization at the place of origin of this application.

The date of termination of the insurance contract is the date of the failure of the policyholder from the insurance contract.

This insurance contract shall be terminated:

- when the Insured or his authorized representative submits to the Insurer a written application of the Insured about the cancellation of the insurance contract - from the moment the Insurer accepts this application;

- when sending a declaration of withdrawal from the insurance contract by mail - from 00.00 am, the date of cancellation of the insurance contract at the local time of departure of the statement.

7.11. If the Insured refuses to have an insurance contract within 14 (fourteen) calendar days from the date of its conclusion (unless another term is specified by the Instructions), if there are no events in the given period showing signs of an insured event, the insurance premium will be returned to the Insured or its part in the manner specified The insurer in the application for insurance payment, in a period not exceeding 10 (ten) working days from the date of receipt by the Insurer of a written application of the Insured about the cancellation of the insurance contract drawn up in arbitrary form.

7.12. In other cases, if the Insured refuses the insurance contract, the insurance premium is not refundable, unless otherwise provided by the insurance contract.

8. RIGHTS AND OBLIGATIONS OF THE PARTIES

8.1. *The Insurer shall*:

8.1.1. issue an insurance policy to the Policyholder;

8.1.2. upon occurrence of an insured event, to make an insurance payment within the period established by these Rules or an insurance contract, and if there are no grounds for this, send a reasoned conclusion to the Beneficiary (Insured) to refuse to pay the insurance payment;

8.1.3. to not disclose information about the Policyholder (Insured Person), Beneficiary and their property status and state of health, if this does not conflict with the legislative acts of the Russian Federation;

8.1.4. according to the requirements of the Insured (Insured person), Beneficiary, as well as persons intending to conclude an insurance contract, clarify the provisions contained in these Regulations and the insurance contract.

8.2. The Insurer has the right:

8.2.1. independently examine the causes and circumstances of the event. If necessary,

request from the Insured (Insured person) materials of judicial or investigative bodies, documents drawn up by the carrier, certificates, invoices and other documents confirming the fact of the incident, its details and consequences;

8.2.2. In order to make a decision on the qualification of an event qualifying as an insured event, to require the Insured to undergo a survey (examination) in a healthcare organization specified by the Insurer in the scope established by the Insurer and sufficient for making a decision. Such medical examinations (review) shall be carried out at the expense of the Insurer.

8.2.3. check the information provided by the Insured (Insured person), as well as the fulfilment of their duties by the Insured;

8.2.4. make recommendations to the policyholder for the prevention of accidents;

8.2.5. to not make an insurance payment, in cases stipulated by the Insurance Rules and the current legislation of the Russian Federation;

8.2.6. require the fulfilment of other conditions stipulated by law and the insurance contract;

8.2.7. to involve third parties in order to conclude and execute the insurance contract (including insurance agents, insurance brokers, organizations engaged in the transfer, storage and processing of data on the Insureds and the Insured persons).

8.3. *The policyholder (the insured person) shall*:

8.3.1. pay the insurance premium in accordance with the terms of the insurance contract prior to the start of the trip;

8.3.2. during the validity period of the insurance contract, observe personal security measures, comply with the rules established for passengers of the type of transport by which they are being transported, as well as the rules for staying at the stations, stations, airports, ports, bus stops, etc.;

8.3.3. inform the Insurer of the occurrence of the event having signs of an insured event within the terms established by the insurance contract and these Rules;

8.3.4. ensure the safety of the insurance contract and documents related to the insured event;

8.3.5. provide all possible documentary evidence of the insured event occurred to the Insured Person with subsequent submission to the Insurer;

8.3.6. inform the Insured of their rights, obligations and insurance conditions;

8.3.7. immediately contact a healthcare organization and strictly follow the recommendations of specialists of healthcare organization, which perform preventive measures related to the accident;

8.3.8. comply with the terms hereof.

8.4. The Insured has the right to:

8.4.1. obtain these Rules from the Insurer or the opportunity to familiarize with them on the website of the Insurer or from the representative of the Insurer;

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

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

8.4.4. require the Insurer to fulfil other conditions stipulated by the insurance contract and not inconsistent with the legislation of the Russian Federation.

8.5. The Insurer shall be entitled to demand from the Beneficiary, inter alia when the Insured Person is the Beneficiary, performance of the obligations under the insurance contract, including obligations assigned to the Insured, but not performed by him/her, upon presentation of the claim for insurance payment by the Insured. The risk of consequences of non-performance or untimely performance of obligations which had to be performed earlier, is assumed by Insurant.

8.6. The beneficiary is entitled to receive the insurance payment in the manner and amount stipulated by these Rules, the insurance contract.

9. DUTIES OF THE INSURER (INSURED PERSON) AT THE EVENT QUALIFYING AS AN INSURANCE EVENT

9.1. Upon occurrence of the event that having signs of the insured event, the Insured (insured person or their representative) shall:

- contact the train manager (authorized carrier representative - for other types of transport) to draw up an act (document) about an accident with an insured passenger during a transport trip;
- contact the train manager of the railway station, airport, port station to draw up an act (document) about an accident with an insured passenger while in the railway station, airport, port;
- upon arrival at the destination immediately, no later than 24 hours from the moment of arrival, arrange the Insured's visit to the medical organization for medical assistance and subsequently receive the necessary documents confirming the injury, its character (diagnosis), the duration of continuous treatment and temporary disability, medical events and other information;
- within no more than 30 days from the moment of occurrence of an event qualifying as an insured event, notify the Insurer or its representative about injury or death of the Insured person in writing or by any fixed method of communication (the Beneficiary, heirs of the Insured person may also fulfil this obligation);
- provide the Insurer with the documents necessary for the Insurer to make a decision on recognition or non-recognition of an event as an insured event (the Beneficiary, heirs of the Insured person may also fulfil this obligation).

9.2. Depending on the nature and circumstances of the event having signs of an insured event, the Insurer may request documents from the Insured (Beneficiary, Insured person, heirs) based on a specific insured risk, a list of which is established in this Section of the Insurance Rules (taking into account cl. 9.5 hereof).

The insurer has the right to reduce the list of required documents, if the circumstances of the insured event or the size of the damage caused in accordance with the previously provided documents are known or obvious to him.

To resolve the issue of recognition/non-recognition of the declared event as an insured event, the Insurer must submit the following documents to the Insurer by the Beneficiary (Insured, heir, heirs):

a) insurance policy, list of insured persons (if available);

b) written application of the Insured person (Beneficiary, heirs) for the insurance payment in the form established by the Insurer, indicating the method of receiving the insurance payment (to transfer to a bank account, it is necessary to indicate full bank details);

c) documents necessary in accordance with the requirements of the current legislation of the Russian Federation for the identification of the person who applied for the insurance payment, including the identity document;

d) consent to the processing of personal data, as well as special category data (including medical confidentiality) - in cases where, according to the legislation of the Russian Federation, the Insurer is not entitled to process personal data without such a consent;

e) a document confirming the authority of the person, who is the representative of the Insured, Beneficiary or heir;

f) travel document (ticket) confirming, that the Insured person was a passenger and travelled by vehicle on the route specified in the ticket, at the time of the occurrence of an event qualifying as an insured event (original or copy certified by the carrier);

g) a document about the accident and its circumstances, drawn up in the manner determined by the rules for the carriage of passengers in the type of transport in which the carriage was carried out:

- the statement of the accident drawn up by the carrier, if the accident occurred along the line of the vehicle or at the time of embarkation/disembarkation of the passenger;

- the act of the accident drawn up by the responsible employees of the railway station (station), airport, port, if the accident occurred on the territory of the roadside station, station, airport, port;

- additionally, at the request of the Insurer - a document about the occurred event in the vehicle and its details, drawn up in the manner determined by the rules of the passenger carriage with the relevant type of transport, confirming that the passenger has been harmed which is executed by the carrier or a person authorized by the carrier for each victim and contains the following information:

  - date, time, place of execution;
  - type of transport, route (flight) number and other signs identifying the vehicle (state registration number, serial number, etc.);
  - full name of the carrier in accordance with the certificate of state registration of a legal entity or an individual entrepreneur;
  - surname, name, patronymic of the victim (if it is possible to establish it);
  - place of the event;
  - description of the event and its circumstances;
  - the nature of the harm caused to the passenger (harm to life, harm to health), with a description of visible damage, if it possible to establish such damage visually;
  - information about witnesses (if available) with contact information;
  - signature, surname, initials of the carrier's official, certified with the stamp of the carrier or the person authorized by the carrier;

h) documents of investigation by the competent authorities of the fact of the stated event, if such an event is subject to investigation in the manner established by the legislation of the Russian Federation;

i) documents of law enforcement agencies about the circumstances of the event;

j) the results of chemical analysis for content of alcohol-containing, narcotic, toxic substances upon admission to the hospital (if conducted);

k) a copy of the emergency call card.

9.2.1. Moreover, in connection with the occurrence of the risk of "Temporary loss of general working capacity as a result of an accident" or "Permanent loss of general working capacity (disability) as a result of an accident", the Insurer is provided with the following documents:

- in inpatient treatment, an epicrisis discharge (extract) from the inpatient's medical record (extract from the medical history) from the date of the initial appeal for the reported event (original or duly certified copy);

- in outpatient treatment, an extract from the outpatient's medical record from the date of the initial appeal for the reported event (original or duly certified copy) for the entire period of treatment. The document must contain a stamp and seal of the health facility;

- copies of disability certificates issued for payment, certified by a personnel department / personnel management officer and the seal of the personnel department / personnel management organization in which the Insured person works, or copies of a certificate of exemption from the student's or student's pre-school exemption certified in the prescribed manner institutions; certified in the prescribed manner copies of certificates of temporary disability (exemption sheets for temporary disability) for certain categories of citizens (employees of the Ministry of Internal Affairs, Ministry of Emergency Situations, Ministry of Defense, etc.);

- medical documents indicating the full clinical diagnosis, treatment duration, therapeutic and diagnostic measures for the duration of treatment; from all medical institutions in which the Insured received medical assistance in connection with the declared event;

- certificate of the MSA Bureau on the establishment of a disability group or category "disabled child" (original or notarized copy);

- referral for medical and social expertise, reverse coupon of the MSA Bureau, protocol of

the MSA performance (duly certified copies);

- original or notarized copy of the pension certificate (for the pensioners);
- original or notarized copy of employment record or certificate from the employment center (for non-working persons).

9.2.2. Moreover, with the onset of the insured risk “Death as a result of an accident”, the Insurer is provided with the following documents:

- death certificate of the Insured person (original or notarized copy);
- a copy of a medical death certificate;
- a copy of a forensic medical examination report with the results of forensic chemical, forensic histological and other research, duly certified (if an autopsy was performed);
- a copy of the relatives statement on the waiver of the autopsy and a copy of the certificate from the pathoanatomical department, on the basis of which a death certificate is issued (if no autopsy was performed);
- a copy of the document (passport or document replacing it), certifying the identity of the recipient of the insurance payment under the insurance contract, with a note about registration at the place of residence;
- the original of the order of the Insured person, about whom he designated as the recipient of the insurance payment in the event of his death;
- in the absence of an order of the Insured person about designation of the beneficiary in the event of their death - documents confirming accession to the heirship in respect of the insurance payment under the insurance contract (certificate of inheritance or certificate of the amount of all the heirs of the Insured person dated not earlier than 6 months from the date of opening the inheritance).

9.2.3. If the relevant competent authorities initiates a criminal case related to the declared event or investigates the circumstances leading to the declared event, the outcome of which determines the decision on qualification of the event as the insured event, the Insured (Beneficiary), at the request of the Insurer, is also required to provide documents confirming the termination or suspension of criminal proceedings (whichever comes earlier).

9.3. If an event qualifying as an insured event to the Insured outside the Russian Federation, while a vehicle of international traffic is traveling, and medical assistance was provided in the territory of the foreign country, then the Insurer should be provided with medical and other documents to establish the occurrence of the insured event with the Insured person, the nature of the damage received by him, with an apostille stamped on them (at the request of the Insurer). Documents in a foreign language are provided with a notarized translation. The cost of collecting these documents and their transfer are not refunded by the Insurer.

9.4. The insurer shall be submitted documents issued and executed by a medical organization in accordance with the procedure established by the legislation of the Russian Federation (indicating the name, patronymic name of the Insured person, date of birth/age, basic clinical diagnosis, etc.), certified by the seal of the medical institution.

If the legal representative of the Insured person or the Beneficiary (parents, adoptive parents, guardian, caregiver) applies for the insurance payment, the Insurer should be provided with the documents confirming the authority of the legal representative.

If the Insured/Beneficiary authorizes a third party to receive the insurance payment, a notarized power of attorney for the right to receive the insurance payment must also be submitted.

All documents stipulated by this Section and provided to the Insurer in connection with insurance payments shall be drawn up in Russian. If the documents provided to the Insurer are issued on the territory of a foreign state, then they must be properly legalized, incl. have an apostille (if applicable) and/or a notarized translation. In the case of the provision of documents, which cannot be read due to the handwriting peculiarities of the doctor or employee of the competent authority, as well as due to violation of the integrity of the document, the Insurer has

the right to postpone the decision on the stated event until the documents are of good quality.

9.5. Documents provided in accordance with the sub-cl. 9.2 - 9.4 hereof, shall allow the Insurer to qualify the declared event as an insured event within the framework of the concluded insurance contract. Otherwise, the Insurer is entitled within 10 (ten) working days after the Insurer receives the last of the documents provided by the Insured (Beneficiary) (sub-cl. 9.2 - 9.4 hereof), to inform the Insured (Beneficiary) about the incompleteness of the set of documents provided and the need for the Insured (Beneficiary) to provide documents and information containing the necessary and sufficient information, or to request documents from competent authorities and organizations, expert organizations, other organizations and bodies that allow to make an unambiguous conclusion about whether the event is an insurable event covered by the insurance contract or not.

The insurer has the right to carry out an examination of the documents submitted, independently clarify the causes and circumstances of the insured event.

In case of doubts about the authenticity and/or reliability, as well as the sufficiency of documents submitted by the Insured person (Beneficiary) in connection with the occurrence of an event having signs of an insured event, or to confirm the state of disability, including when assigning a disability group, The Insurer has the right to ask the Insured to repeated laboratory and instrumental examinations (including ultrasound examinations, X-ray and other methods of radiation diagnosis), repeated medical examinations carried out by doctors of various specialties. These studies and medical examinations are carried out by doctors designated by the Insurer at the places designated by the Insurer and at their expense.

The Insured, Beneficiaries are obliged to provide the Insurer or its representative with free access to information relating to the insured event.

10. AMOUNT AND PROCEDURE FOR INSURANCE PAYMENT

10.1. Insurance payment - a sum of money established by the insurance contract and paid by the Insurer to the Insured (Insured person, Beneficiary) upon the occurrence of an insured event.

10.2. The insurance payment is made by the Insurer to the Insured person (Beneficiary), the heirs of the Insured person (or their legal representatives (parents, adoptive parents, guardian, guardian) in accordance with applicable law) within the limits of the individual insurance amount specified in the insurance contract.

10.3. Upon the occurrence of an insured event, the amount of the insurance benefit is determined in accordance with the terms of the insurance contract:

10.3.1. Upon the occurrence of the insured event “Temporary loss of general working capacity as a result of an accident”, the insurance payment is made to the Insured person “by the number of days of temporary disability” (continuous treatment) - the insurance payment is 0.3% of the insured amount 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 insured amount established by the Insured.

10.3.1.1. An insurance contract may provide for a different amount of payments for the day of temporary loss of general working capacity, given that:

− the percentage of payments for the day of temporary loss of total working capacity cannot be less than 0.01% and more than 3.00% of the insurance sum.

The number of days of loss of general working capacity or temporary health impairment is calculated from the date of applying for medical care to a medical organization on the basis of medical documents issued by a medical organization (certificates, extracts, discharge certificates, outpatient cards), as well as documents confirming temporary disability, temporary disorder of health, terms of continuous treatment (disability certificates, conclusion of the medical commission, exemption sheets on duty disability, certificates of temporary disability for certain categories of citizens (employees of the Ministry of Internal Affairs, Ministry of Emergency

Situations, Ministry of Defense, etc.), certificates of exemption of a student, student, certificates of exemption from attending a kindergarten).

10.3.1.2. In the insurance contract, a different maximum period of continuous treatment may be established, which is paid in connection with one insured event.

10.3.1.3. The insurance contract may set the maximum insurance payment for one insured event.

10.3.2. Upon occurrence of the insured event “Persistent loss of general working capacity (disability)” as a result of an accident” for persons, who are not disabled before the conclusion of the insurance contract, the insurance benefit is paid to the Insured in the following amounts of the insurance sum (unless otherwise provided by the insurance contract), depending on established disability group:

with the I group of disability - 100% of the sum insured;

with the II group of disability - 70% of the sum insured;

with the III group of disability - 40% of the sum insured.

For persons who belong to the III disability group before entering into an insurance contract, the insurance payment is made to the Insured in the following amounts of the sum insured (unless otherwise provided by the insurance contract) depending on the disability group determined:

with the I group of disability - 100% of the sum insured;

with the II group of disability - 70% of the sum insured.

For persons who belong to the II disability group before entering into an insurance contract, the insurance payment is made to the Insured in the following amounts of the sum insured (unless otherwise provided by the insurance contract) depending on the determination of the disability group:

with the I group of disability - 100% of the sum insured;

When a “disabled child” is established for a child under the age of 18, the insurance payment amount is 100% of the sum insured.

If, as of the date of the insurance contract concluding, the category “disabled child” has already been established and not cancelled for the insured person, the insurance payment for this risk is not made.

10.3.2.1. If disability of the III group is confirmed for the Insured Person and a lump sum insurance payment was made thereto when the Insured Person is assigned the II group disability due to the same accident, the insurance payment shall be made in the amount of the difference between the group III disability and group II disability.

If disability of the II group is confirmed for the Insured Person and a lump sum insurance payment was made thereto when the Insured Person is assigned the I group disability due to the same accident, the insurance payment shall be made in the amount of the difference between the group II disability and group I disability.

Insurance payments in the amount of the arising difference will be made if the Insurer has announced a change in the group of disability within one year after the occurrence of the insured event and the relevant documents have been provided.

10.3.3. Upon occurrence of the insured event “Death as a result of an accident” the insurance payment is made to the Beneficiary or to the heir (s) in the amount of 100% of the insured amount;

10.3.4. In cases, where after the insurance payment for temporary loss of general working capacity or temporary disruption of health the Insured person became disabled or died due to the same accident, the total amount of insurance payments to the Insured may not exceed the sum insured.

10.4. The insurance payment is made by the Insurer in accordance with the insurance contract on the basis of the application of the Insured, the Beneficiary (or their legal representatives in accordance with the applicable law), the heirs of the Insured and the insurance

act drawn up by the Insurer.

10.5. The insurance payment is made to the Insured person, Beneficiary, heirs of the Insured person (or their legal representatives in accordance with applicable law) by transfer to the account specified in the application for insurance payment, or by any other method chosen in the application for insurance payment, in accordance with applicable law.

10.6. If the declared event is recognized as an insured event, the insurance act is compiled and the insurance payment is transferred by the Insured person (Beneficiary) or the heir (s) of the Insured within 10 (ten) working days from the moment the Insurer receives all necessary documents specified in cl. 9.2 - 9.5 hereof,

10.7. In the event that the death of the Policyholder (the Insured) is due to a deliberate action by the Beneficiary that caused the occurrence of the insured event, the insurance benefit is paid to another Beneficiary (Beneficiaries). If one Beneficiary was appointed under the contract, then the insurance payment in this case is made to the heirs of the Insured in the manner prescribed by law.

10.8. If the Beneficiary has applied to the Insurer to receive the insurance payment and has died before he/she received the amount of insurance payment due to him/her, then the payment shall be made to his/her heirs on the basis of a certificate of inheritance, a certificate of the circle of all heirs of the Beneficiary dated not earlier than 6 months from the date of opening the inheritance.

10.9. If the event is not recognized as an insured event, the Insurer shall notify the Person that applied for a payment in writing with justification of the reasons for refusal within 10 (ten) business days from the date of submission by the Policyholder, the Insured, Beneficiary of all necessary documents specified in cl. 9.2 - 9.5 hereof,

11. DISPUTE SETTLEMENT PROCEDURE

11.1. Disputes arising under the insurance contract concluded under the terms of these Rules shall be settled in the manner prescribed by the legislation of the Russian Federation.

Settlement of disputes with legal entities or individual entrepreneurs shall be carried out in compliance with the pre-trial (claim) procedure, unless otherwise provided for by the insurance contract. In the course of settlement of a dispute using the pre-trial (claim) procedure, before applying to court, a reasoned written claim shall be sent with copies of the documents referred to in the claim. The entity to whom the claim is sent shall, within 30 calendar days from the date of receipt of the claim, unless otherwise provided for by the insurance contract, review it and notify the entity submitting the claim in writing of the results of its consideration. If the dispute has not been settled using the pre-trial (claim) procedure, it shall be resolved in court in accordance with the current legislation of the Russian Federation.