HEALTH INSURANCE REGULATION No. 06-2021

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1. Terms used in the Regulation

Insurer – European association (SE) ERGO Life Insurance, included in the Registry of Legal Entities of the Republic of Lithuania under registration No. 110707135, registered address: Geležinio Vilko 6A, LT-03507, Vilnius, Lithuania), represented in the Republic of Latvia by **ERGO Life Insurance SE Latvian Branch** (included in the Register of Enterprises of the Republic of Latvia under unified registration No. 40103336441, registered address: Skanstes iela 50, Riga, LV-1013.

Policyholder – a legal entity which signs the health Insurance Agreement for the benefit of the Insured Person;

Insured Person – the natural person specified in the Insurance Policy with an insurable interest and for whose benefit the Insurance Agreement for health insurance has been concluded between the Insurer and the Policyholder;

Insurance Risk – expenses anticipated in the Insurance Agreement, connected with receiving the services of the Service Provider's institution, which may be incurred to the Insured Person during the Insurance Period, and the payment for which has been anticipated in the Insurance Agreement of the Insured Person**;**

Insurance Event – an event with a causal relationship to the Insurance Risk, upon which during the effective period of the Insurance Agreement, an Insurance Indemnity is to be paid under the Insurance Agreement;

Insurance Card – an Insurer's acknowledgement issued in an electronic or physical form regarding the insurance of the Insured Person for the Insurance Period within the Insurance Plan; if issuing an Insurance Card is not provided for in the Insurance Agreement, it shall not affect the validity of the Insurance, if all the conditions for the entry into force of the Insurance Agreement have been complied with;

Insurance Limit – the amount of money or the number of medical treatment services or visits specified in the Insurance Plan, within which the Insured Person's healthcare service expenses are covered in the case of an Insurance Event;

Insurance Agreement – the agreement between the Insurer and the Policyholder by which the Policyholder undertakes to pay the Insurance Premium in the established manner, within the established timelines and in the fixed amount as well as comply with the other provisions of the Agreement, and, in the case of an Insurance Event and Insurance Expenses related thereto, the Insurer undertakes to pay the Insurance Indemnity to the person specified in the Insurance Agreement under the provisions of the Insurance Agreement; the subject-matter of the Insurance Agreement shall be considered to be the insurance object established in the Insurance Agreement, the total of the insured risks and the exclusions established, as well as the insurance amount.

The Insurance Agreement consists of: Application for Insurance, List of Insured Persons, Health Insurance Offer Request Form, Health Insurance Offer, Insurance Policy, Insurance Card, this Health Insurance Regulation, Annexes to the Insurance Policy, Insurance Plan, other regulations and/or amendments to the insurance agreement, the Insurer and the Policyholder have agreed upon in writing and which are integral parts of the Insurance Agreement;

Insurance Object – the health of the Insured Person;

Insurance Period – the time period indicated in the Insurance Policy, when the Insurance is in force;

Insurance Application – a document defined by the Insurer or any other information that the Policyholder must submit to the Insurer to inform the Insurer of the Insured Interest, and of the facts and circumstances required for the assessment of the Insurance Risk;

Insurance Policy – a document that certifies the signing of the Insurance Agreement; the absence of signatures of the parties on the Insurance Policy shall not affect the validity of the Insurance Agreement, if all the regulations for the entry into force of the Insurance Agreement have been complied with;

Insurance Premium – the payment to be made by the Policyholder for the insurance according to the calculation provided by the Insurer;

Insurance Plan – a set of healthcare services (coverage) established by the Insurer and the amount payable by the Insurer in the case of an Insured Event and fixed in the Insurance Agreement;

Insurance Amount – the maximum amount of money, specified in the Insurance Agreement, that the Insurer can pay to cover the healthcare services received by the Insured Person within the chosen Insurance Plan;

Insurance Indemnity – the amount of money to be paid and/or the services to be provided for the Insurance Event in accordance with the Insurance Contract;

Application for Insurance Indemnity – the document provided by the Insurer which the Insured Person submits to the Insurer in order to receive the Insurance Indemnity under the provisions of the signed Insurance Agreement;

Treatment – professional and individual prevention, diagnostics and treatment of illnesses, medical rehabilitation and patient care;

Medical Institution – a doctor's practice, state or local government institution, economic operator, an association entered into the Registry of Medical Institutions, compliant with the mandatory requirements established for medical institutions and their structural units in the laws and regulations effective in the Republic of Latvia, and providing medical treatment services;

Medical Treatment Service – a service which the Insured Person has received in the Medical Institution from a Medical Specialist, who in accordance with the procedure prescribed in the laws and regulations of the Republic of Latvia may provide services in a specific speciality and apply the medical technology – a method used for treatment and approved by the procedure established by the Cabinet, and a medical device or medical products conforming to the requirements and released in the market according to the requirements established in respect of them in the laws and regulations of the Republic of Latvia;

Medical Specialists – persons with medical education and engaged in Treatment activities;

Contractual Institution – a service provider institution with which the Insurer has signed an agreement on certain services and which, in the case of an Insurance Event, provides services to the Insured Person within the Insurance Plan. Payments for the services provided to the Insured Person by the Contractual Institution are effected by the Insurer in accordance with the provisions of the Insurance Agreement;

Service Provider – a Medical Institution as well as pharmacies and optics institutions duly operating in the territory of the Republic of Latvia in accordance with the procedures established in the laws and regulations effective in the Republic of Latvia to provide medical treatment, prevention, and rehabilitation services, and the institutions providing sports services where the services for the improvement of health and preventive services are provided by certified sports specialists in accordance with the procedures established in the laws and regulations effective in the Republic of Latvia;

Personal Data Processing – any activity or set thereof, automated or not, performed with personal data or sets of personal data such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, review, use, disclosure by transmission, dissemination or otherwise making available, matching or combination, limitation, erasure or destruction;

The terms used in this regulation are applicable in all the documents of the Insurance Agreement that the regulation is part of.

2. Law applicable to the Insurance Agreement

2.1 Concluding the Insurance Agreement, the Parties hereby agree that the laws and regulations of the Republic of Latvia shall apply to the fulfilment of the obligations arising from the Insurance Agreement, including the Latvian Republic Insurance Contract Law, and the regulations of the European Union applicable in the Republic of Latvia. In the case of amendments to effective laws and regulations resulting in the terms and conditions of this Insurance Agreement being in conflict with the applicable law, the effective law shall apply to the fulfilment of the Insurance Agreement and its respective obligations, unless otherwise indicated in the laws and regulations.

2.2 Any issues not discussed in the Insurance Agreement, including in this Regulation, are resolved between the parties in accordance with the laws and regulations in force in compliance with Paragraph 2.1 of the Regulation.

3. Conclusion and Effect of the Insurance Agreement; Payment of the Insurance Premium

3.1. The Insurance Agreement shall only be considered concluded, when the Insurer and the Policyholder agree on all the terms and conditions of the Insurance Agreement. Conclusion of the Insurance Agreement shall be certified by the Insurance Policy issued by the Insurer.

3.2. Unless it is determined otherwise in the Agreement, the Insurance Agreement shall come into force on the day determined in the Insurance Policy, if the Policyholder has paid the Insurance Premium within the planned deadline and in the planned amount.

3.3. The Policyholder shall be required to pay the Insurance Premium by the date specified in the Insurance Agreement. In the event of disputes, the date on which the Insurer receives the Insurance Premium in the Insurer's indicated bank account, shall be decisive.

3.4. Throughout the effective period of the Insurance Agreement, the Insured Persons shall be added to or deleted from the List of Insured Persons based on written information submitted by the Policyholder to the Insurer about changes to the List of Insured Persons.
3.5. The Insurance is in force within the territory of the Republic of Latvia, excluding the cases when the parties have agreed otherwise in written form.

4. Obligations and Liability of the Parties for Breaching the Terms and Conditions of the Insurance Agreement

4.1. The Parties have an obligation to follow the Regulation of the Insurance Agreement and the laws and regulations of the Republic of Latvia. The Parties shall be held liable for breaching the terms and conditions of the Insurance Agreement in accordance with the procedure prescribed by the Civil Law of the Republic of Latvia and other laws and regulations.

4.2. **Rights and Obligations of the Policyholder, the Insured Person**

4.2.1. <u>The Policyholder hereby undertakes to:</u>

4.2.1.1. inform the Insured Persons that they are being insured, introduce them to the regulations of the Insurance Agreement or changes to them, explain the rights and obligations resulting from the Insurance Agreement and submit the documents prescribed in the Insurance Offer to the Insurers;
4.2.1.2. timely submit the List of Insured Persons to the Insurer;
4.2.1.3. before the date when the changes enter into force, timely submit the information about adding or excluding persons from the List of Insured Persons to the Insurer;
4.2.1.4. pay the Insurance Premiums within the timelines, in the manner and the amount specified in the Insurance Agreement;
4.2.1.5. if the Insured Person fails to fulfil the obligations established in Paragraph 4.2.2.6 of this Regulation, within 3 (three) working days upon request, the Policyholder shall return the Insurer the amount received by the Insured Person as the Insurance Indemnity or a Medical Treatment Service:
a) in excess of the Insurance amount or Insurance limits fixed in the Insurance Agreement;
b) in the case that they are not covered by the Insurance Agreement (are beyond the covered range);
c) upon termination of the Insurance Period or the Insurance Agreement;
4.2.1.6. if the Policyholder fails to pay the Insurance Premium within the timeline fixed in the invoice, the Policyholder shall, in addition to the Insurance Premium fixed in the Agreement, pay the forfeit calculated by the Insurer in the amount of 0.5% (zero point five percent) of the part of the Insurance Premium outstanding for each day overdue. Payment of the contractual penalty shall not relieve the Policyholder from the duty to fulfil the obligations.

4.2.2. <u>The Insured Person shall:</u>

4.2.2.1. read the Insurance Plan and this Health Insurance Regulation and comply with them;
4.2.2.2. immediately inform the Policyholder in the case of a change in the Insured Person's rights to receive the state provided healthcare services;
4.2.2.3. Care about their health and, in the case of an Insurance Event, follow the instructions given by the medical specialist in order to reduce the costs of medical treatment;
4.2.2.4. monitor their Medical Treatment Costs in order not to exceed the Insurance Amount and/or the Insurance Limit;
4.2.2.5. not use the Insurance Card, if the limits of the disbursed Insurance Indemnity or Insurance limits have reached the amount prescribed in the Insurance Agreement and the Insurance Plan;
4.2.2.6. no later than within 14 (fourteen) work days after the Insurer's request, pay the Insurer the amount of money that the Insured Person has received as Insurance Indemnity or Medical Treatment Services contrary to that which is stipulated in Paragraph 4.2.2.5 of the Regulation;
a) in excess of the Insurance amount or Insurance limits fixed in the Insurance Agreement;
b) in the case that they are not covered by the Insurance Agreement (are beyond the covered range);
c) after termination of the Insurance Period or the Insurance Agreement;
4.2.2.7. immediately after the receipt of the service, as soon as possible, submit the Insurer the following documents for the services included in the health insurance plan for which the Insured Person has paid individually:
a) an Insurance Indemnity Application filled according to the Insurer's prescribed procedure.
b) the original personalised payment document or a copy thereof, certified by the Insured Person, containing information about the received service, its quantity and the price paid for each received service;
c) other documents required by the Insurer for the services received by the Insured Person to confirm the circumstances of the Insurance Event and/or the determination of the amount of the Insurance Indemnity to be paid;
4.2.2.8. in the case that the original payment documents are not attached to the application for the Insurance Indemnity, keep the original justifying payment documents for 3 (three) years after the receipt of the service and produce them for the Insurer at its first request.

4.3. **Rights and Obligations of the Insurer**

4.3.1. In the case of loss of the Insurance Card or any change in the personal data of the Insured Person (if the Card was issued physically), the Insurer shall make a Replacement Card within 5 (five) business days of the date of receipt of the application from the Policyholder or the Insured Person and the receipt of the payment for the replacement Insurance Card. The fee for a replacement Insurance Card in the event of loss shall be EUR 4.00 (four euros). The replacement Insurance Card shall be issued to the Policyholder. Upon the production of confirmation issued by the State Police of the Ministry of the Interior of the Republic of Latvia for the theft of personal documents, the replacement Insurance Card shall be issued free of charge.

4.3.2. Throughout the effective period of the Insurance Agreement, the Insurer shall be entitled to unilaterally introduce restrictions on the covered Medical Treatment Services, require payment of an additional insurance premium, and adjust the insurance coverage if, during the effective period of the Insurance Agreement, new fees are implemented or the existing fees are increased under the provisions of the laws and regulations effective in the Republic of Latvia, changes are made with regard to the healthcare services provided by the State and applicable to the Medical Treatment Services for which an Insurance Indemnity should be paid under the signed Insurance Agreement.

4.3.3. Within the effective period of the Insurance Agreement, the Insurer shall be entitled to change the procedure of payment for the services and/or apply restrictions to the covered services at a Contractual Institution while leaving the volume and amount of the covered services specified in the Insurance Plan unchanged, as well as make changes to the range of services payable in the Contractual Institution and the List of Contractual Institutions. Up-to-date information about the Contractual Institutions is available on the website: www.ergo.lv.

4.3.4. The Insurer has the right to submit a solidary claim for the compensation of losses to the Insured Person and the Policyholder, if the Insurer has not received indemnity of the expenses in accordance with Paragraph 4.2.2.6 and 4.2.1.5 of this Regulation.

5. Decision on the payment of Insurance Indemnity

5.1. Upon the entry in force of the Insurance Case, the Insurer shall pay the Insurance Indemnity according to the principle of compensation, compensating the expenses of the Insured Person incurred while receiving the services at the Service Provider's institution, upon the condition that they shall not be in excess of the Insurance Amount and/or the Insurance limits, and/or the amount fixed in the Insurance Agreement.

5.2. The Insurance Indemnity shall be paid by the Insurer in accordance with Paragraph 5.1, as follows:

5.2.1. To the Contractual Institution (if the Insured Person has received the service in the Contractual Institution);

5.2.2. To the Insured Person, in the case that the:

(a) Insured Person has received the service in the Service Provider's Institution, which is not a Contractual Institution, or

(b) The Insurer does not pay for the service in the Contractual Institution and the Insured Person has paid for the received services included in the Insurance Plan in accordance with the payment documents duly issued by the Service Provider's institution without exceeding the amount of the Insurance Indemnity or the pricelist fixed by the Insurer, or the amount fixed in the Insurance Plan.

5.3. Should the price of the service received from a Service Provider or approvable by the Insurer exceed the amount of the Insurance Indemnity fixed by the Insurer for the service or the pricelist fixed by the Insurer, the excess amount shall be covered by the Insured Person.

5.4. The Insurer shall take the decision to grant or refuse Insurance Indemnity within 10 (ten) days after receiving all the necessary documents and determining the full scope of damage.

5.5. If the Insurer establishes that the documents submitted for receipt of the Insurance Indemnity are incomplete, filled in incorrectly and/or additional time is required for the examination of the Insurance Event or verifying the submitted documents, the Insurer may extend the term for making the decision by up to 30 (thirty) days, informing the Insured Person.

5.6. Should the Insurer decide to refuse to issue the Insurance Proceeds, then within 10 (ten) days after the decision, the Insurer shall send a reasoned notification to this effect to the person entitled to claim the Insurance Proceeds. The Insurer has the right to send the notification mentioned in this Paragraph to the e-mail address, if the Insured Person has indicated it for communication purposes, in accordance with the procedure laid out in Paragraph 7.3 of the Regulation. The Insured Person shall notify the Insurer if, in addition to the information received, they also wish for the decision to be sent to a postal address specified by them.

6. Termination of the Insurance Agreement

6.1. The duration of the Insurance Agreement is specified in the Insurance Policy. The Insurance Agreement may be terminated early, subject to written agreement between the Policyholder and the Insurer.

6.2. Any of the Parties may terminate the Insurance Agreement early, after the occurrence of the Insurance Event, provided that the Insurance Indemnity has been paid.

6.3. The Policyholder shall be entitled to unilaterally withdraw from the Insurance Agreement, notifying the Insurer of this in writing. The Insurer shall resolve to terminate the Insurance Agreement subject to the Policyholder's notification regarding their withdrawal from the Agreement.

6.4. The Insurance Agreement may be terminated in the cases determined in the Insurance Contract Law or other laws and regulations of the Republic of Latvia, including, the Insurer may terminate the Insurance Agreement in the case if information has changed regarding the possibility of the occurrence of the insured risk and the possible amount of losses during the validity period of the Insurance Agreement.

7. Submission of Notifications, Requests and Information

7.1. The Policyholder and/or the Insured Person shall submit all notifications, claims and applications pertaining to the Insurance Agreement and liabilities arising therefrom (including the Insurance Application, information about the Insured Interest, facts and circumstances required for assessment of the insured risk, changes to the contact information) to the Insurer in writing, on the website www.ergo.lv, by sending it to the registered address of the branch of the Insurer, or electronically by using the e-mail address specified by the Insurer.

7.2. The Policyholder or the Insured Person shall submit all notifications, claims and applications pertaining to the Insurance Agreement and liabilities arising therefrom to the Insurer in such a form and type that enables the Insurer to clearly identify the Policyholder or the Insured Person as the submitter of the document.

7.3. The Insurer shall submit notifications, applications and claims referred to in the Insurance Agreement (including the Insurance policy and other documents) in writing to the postal address of the Policyholder and/or Insured Person specified. The Insurer shall be entitled to send the necessary information to the Policyholder and/or Insured Person to the e-mail address specified, if the Policyholder/the Insured Person has specified it for the receipt of said information in the Insurance Agreement.

7.4. The Insured Person shall be obliged to immediately inform the Policyholder in the case of a change in the contact information submitted for communication with the Insured Person.

7.5. The Insurer shall inform the Policyholder about changes to the contact information of the Insurer, the Insurance terms and conditions or laws and regulations applicable to the Insurance Agreement on the website of the Insurer at www.ergo.lv, or send said information to the address of the Policyholder specified.

8. Exceptions

8.1. By signing the Insurance Agreement, the parties agree that, excluding the healthcare services paid by the state in the amount of the patient's co-payment, the following will not qualify as an Insurance Event and that no Insurance Indemnity will be paid for:

8.1.1 services received at an institution which is not a Service Provider's institution;

8.1.2 medical treatment services provided outside the address of the Medical Institution (externally), except for emergency medical aid and home visits of medical personnel;

8.1.3. doctors' fees, doctor's choice for surgery, services rendered outside the working hours of doctors, doctors' councils, administrative expenses, outpatient and inpatient service services, preliminary medical health checks for vehicle drivers;

8.1.4 paid treatment of disorders caused by oncology – malignant tumours and health disorders caused by them (excluding diagnostics until the moment of establishment of the diagnosis of a malignant tumour), palliative treatment, social care, staying overnight in an outpatient clinic, individual post in an in-patient facility, catering, treatment of sleeping disorders and illnesses, individual healthcare agreements (excluding delivery agreements);

8.1.5 cosmetic services and/or treatment, photo-dynamic laser therapy, photothermolysis, aesthetic dermatology and surgery services, treatment courses and programmes (including juice, dietary treatment courses), weight reduction programmes, lymphatic drainage, full-body massage, vacuum massage, foot care;

8.1.6. treatment and diagnosis of fungal diseases; Acne and Rosacea treatment, autohemotherapy (including PRP, PRF injections) and capsule endoscopy; magnetic resonance imaging for the whole body, positron issue tomography (PET/CT), stereotactic radiosurgery;

8.1.7. treatment, using supplementing (complementary) medical services (non-traditional medical methods) if it is not prescribed by the insurance plan (for example, needle therapy, bioresonance therapy and diagnostics, Ayurvedic medicine, etc.);

8.1.8. birth control, contraception, infertility treatment, medically assisted procreation, services related to the termination of pregnancy without medical indications and treatment of the consequences of such termination;

8.1.9. heart and cardiovascular surgeries, vascular stenting and bypass stent surgeries, coronarographies, services of placement/removal of electrocardiostimulators and their checking;

8.1.10. services related to prosthetics of organs, transplantation of organs and tissue, surgeries correcting eye refraction, plastic and reconstructive surgery, tissue-replacing materials, ancillary materials, devices and purchasing of technical ancillary means, means of treatment used in manipulations/surgeries (medicinal products and devices);

8.1.11. treatment of sexually-transmitted diseases and their consequences, including HIV and AIDS, treatment of tuberculosis, treatment of viral hepatitis (except for lab tests for establishing anti HVC and Hbs AG in blood serum);

8.1.12 expenses directly related to the services specified in the insurance agreement as exceptions or services outside the coverage;

8.1.13. expenses for the treatment of disorders resulting from the use of alcohol, narcotic or toxic substances, treatment of mental and behavioural disorders;

8.1.14. expenses incurred due to influences on own health by the Insured Person (Insured Person has intentionally caused body injury and/or affected own health) or self-treatment, and expenses, if the Insured Person has treated itself, using medication or drugs not prescribed by the medical practitioner in charge;

8.1.15. expenses for treatment of trauma or injuries suffered in professional sports (doing sports professionally is when this is the primary occupation or one of the sources of income of the Insured Person);

8.1.16 expenses incurred due to unlawful activities, violations of the law, or criminal acts by the Insured Person (or participation therein), if this has been adjudged by a court or any other competent body;
8.1.17. medical treatment expenses incurred as a result of an epidemic or pandemic – mass spreading of a contagious disease notified by the responsible authority of the Republic of Latvia;
8.1.18 cases when the Insured Person has misled the Insurer deliberately or due to gross negligence;
8.1.19. expenses incurred through the preparation of documents with information of medical content as a separate service, processing of examination digital images, printouts, interpretation and recording in digital data carriers;
8.1.20. services with a receiving or paying date outside the Insurance Period;
8.1.21 cases when the Insured Person has not submitted or cannot submit the Insurer the original documents required by the Insurer to verify the onset of the Insurance Event;
8.1.22. 8.1.26. services provided in the Service Provider's institutions included in the insurance agreement, the services provided by which are not covered by the insurer;
8.1.23. Medical treatment services received without any medical indication;
8.1.24. expenses incurred due to treatment of a condition or an injury diagnosed before the effective date of the Insurance Agreement.

9. Exceptions for international sanctions

9.1. The Insurer shall not cover any losses, and the Insurance Indemnity shall not be paid should it contradict any sanctions (be it trade or economic), prohibitions or limitations imposed by resolutions of the United Nations or law of the European Union, or national sanctions set by the laws and regulations of the Latvian Republic. This exception shall also be subject to trade or economic sanctions, laws and regulations or legislation introduced in the United Kingdom or United States of America, if this does not violate the law effective in Latvia.
9.2. Should the circumstances specified in Paragraph 9.1 of these Terms and Conditions arise during the Insurance Agreement, the Insurer shall be entitled to unilaterally terminate the Insurance Agreement by informing the Policyholder of this in writing.

10. Distance Insurance Agreement Terms and Conditions

10.1. The Insurance Agreement may be concluded in person or using a means of long-distance communication. If the Insurance Agreement is concluded using any means of long-distance communication, the Policyholder shall submit the Insurer a filled-in digital insurance application by using the e-mail address or form indicated by the Insurer.
10.2. A Distance Insurance Agreement shall be deemed concluded as soon as the Insurer sends a prepared Insurance Policy, the Insurance Terms and Conditions, and a bill to the e-mail address indicated by the Policyholder, and the Policyholder pays the Insurance Premium within the time specified.

11. Confidentiality and personal data processing

11.1. The Insurer shall carry out the processing of personal data in accordance with the Insurance Agreement, effective laws and regulations and the Insurer's Privacy Policy available on the Insurer's website, at www.ergo.lv and the Insurer's retail locations. The Insurer's Privacy Policy may be sent to the Policyholder on request.
11.2 The Policyholder shall be required to read the Insurer's Privacy Policy prior to signing the Insurance Agreement, and to inform the parties, whose data are transferred by the Policyholder to the Insurer, of its contents.
11.3 The Insurer shall ensure the confidentiality of any information about the Policyholder and the Insured Person received subject to this Insurance Agreement and the effective laws and regulations, unless the laws and regulations provide for the transfer of such confidential information to third parties.
11.4 Following the procedure, in the cases, and in the volumes established in the laws and regulations of the Republic of Latvia, the Insurer shall provide the information received regarding the Insured Person and the Policyholder to state or local government authorities and other entities or persons.
11.5. The Insured Person is informed that the Insurer may process its personal data, including to request and receive information and documents from medical treatment institutions, drug stores, sports clubs, optical service providers and other institutions and companies regarding the medical condition of the Insured Person, diagnoses, medical, sports or optical services provided to him or her, and any other information needed, related to the Insured Person, to take a decision in the case of Insurance Indemnity, check the circumstances of the Insurance Case entry into force and the compliance of the received service to that which is indicated in the Insurance Policy and/or cooperation agreement between the Insurer and the Contractual Institution.

12. Review of complaints and disputes

12.1. The Insurer shall review and provide a reply to complaints regarding services that breach the provisions of the insurance agreement, prepared and submitted to the Insurer by the Policyholder, Insured Person or other party that is entitled to claim insurance proceeds subject to Paragraph 7.1 and 7.2, within 20 (twenty) days after receiving said complaints. A complaint regarding compliance of the decision made by the Insurer with laws and regulations may be submitted to the Financial and Capital Market Commission.
12.2. All disputes related to the Insurance Agreement shall be resolved through negotiations.
12.3. Should it not be possible to settle the dispute through negotiations, then in certain cases, the Policyholder (a natural person), shall have the right to appeal to the following authorities with a request for extrajudicial review:

12.3.1. Ombudsman of the Latvian Insurers Association: the types of insurance that are within the remit of the Ombudsman of the Latvian Insurers Association are specified on the website of the Ombudsman of the Latvian Insurers Association: http://www.laa.lv/klientiem/ombuds/. The procedure for the review of complaints of the insurers' clients by the ombudsman of the Latvian Insurers Association, as well as the complaint application form are available online, on the official website of the Latvian Insurers Association: www.laa.lv;

12.3.2. Consumer Rights Protection Centre (PTAC), for violations of consumer rights that are not within the remit of the Ombudsman. Additional information is available on the official website of the Consumer Rights Protection Centre, www.ptac.gov.lv.

12.4. A complaint regarding compliance of the decision made by the Insurer with laws and regulations may be submitted to the supervisory authority of the Insurer, the Financial and Capital Market Commission.

12.5. Should no agreement be reached, the dispute shall be filed for review by a court of the Republic of Latvia in accordance with the laws and regulations of the Republic of Latvia.

13. Language of the Insurance Agreement

13.1. The Insurance Agreement shall be prepared and concluded in Latvian. Should the Insurer and the Policyholder agree to do so, the Insurance Agreement may be concluded in Latvian with an additional translation into another language. In such a case, should any contradictions be found between the wording of the Insurance Agreement in Latvian and the wording of the Insurance Agreement in the foreign language, the Latvian wording of the Insurance Agreement shall be decisive.

13.2. In fulfilling the obligations arising from the Insurance Agreement, the Insurer shall communicate with the Policyholder in the official language of the Republic of Latvia (Latvian).